

Transcript of Proceedings:

**TRICARE
Dental Program**

Government Industry Forum

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TRICARE DENTAL PROGRAM
GOVERNMENT INDUSTRY FORUM

Aurora, Colorado
March 30, 2004
8:00 a.m.

APPEARANCES

GOVERNMENT REPRESENTATIVES:

Colonel Mary Concilio

Marjorie Watson

Gene Mayes

Lt. Col. Allen Edwards

Lynn Head

Brian Rubin

Ron Shingler

PROCEEDINGS

1
2 MR. MAYES: Let's get this started, and I'd
3 like to introduce Mr. Brian Rubin, the Deputy Chief of
4 the TRICARE Acquisitions Office.

5 MR. RUBIN: Thank you, Gene. Somebody pull
6 that door, please. As Gene mentioned, we want to
7 welcome you to our industry forum for the TRICARE
8 Dental Program. First of all, I want to thank all of
9 industry for being here today. The Government puts a
10 great deal of stock in what we learn through our
11 industry forums. As we say, it does us no good to
12 bring RFP on the street if it's not attractive to you
13 and to turn into a contract that is easy for us to
14 administrate and administer, and most importantly
15 deliver the quality benefits that we want for our
16 beneficiaries.

17 We've put together an excellent team today,
18 and I'd like to introduce our panel before I go any
19 further. Colonel Mary Concilio, Mary has worked on our
20 current contract, one of our dental project officers,
21 and obviously brings a welcome experience to the table
22 in this particular acquisition. Marjorie Watson,
23 Marjorie is the Contracting Officer on the current
24 contract and will be the Contracting Officer for this
25 acquisition. Gene Mayes, who you've already met a

1 little bit here. Gene works in our program
2 requirements branch, and again, one of our project
3 folks that has worked on all the dental procurements
4 that TMA has put on the street. Lynn Head, you know
5 Lynn. I think most of you do. Lynn is the Contracting
6 Officer's Rep for the Corp on the current contract and
7 will be on the future contract. Between Lynn and Mary,
8 they will serve as the co-project officers for this
9 acquisition. Lieutenant Colonel Al Edwards works with
10 Mary out of our Falls Church office and will be
11 assisting the team here as we put together the
12 requirements for this solicitation. And on the end, to
13 keep us honest, Ron Shingler from our Office of General
14 Counsel. We try to have our legal folks with us as we
15 go through this process as you do. We all need to make
16 sure we follow the rules of engagement.

17 As I mentioned, industry forums are important
18 to us as we try to put together an RFP to put on the
19 street. You can tell by the schedule, that we have
20 allowed plenty of time for this particular effort as we
21 go forward. We have recently completed within TMA a
22 huge acquisition known as TNEX or TRICARE Next
23 Generation of Contracts. And once again, we were
24 reminded of the value of industry forums as we put
25 together our RFP for those contracts. So I thank you

1 for being here, and I encourage you to give this panel
2 any ideas that you may have regarding this particular
3 RFP.

4 Now, the Government has changed a little bit
5 obviously of how we do our procurement, and I will
6 explain that. But I simply want to encourage you to
7 interact with us as much as you possibly can. It is
8 our intent, and as many of you know because you have
9 already participated, we plan to have a website out
10 there, and we're going to be asking information from
11 you, sharing information with you throughout the
12 procurement cycle. We will be posting any questions
13 that come in from any bidders and will be providing the
14 answers to everybody.

15 I also hope that we will have out there draft
16 language that we intend to put in the RFP. Words are
17 hugely important. They are particularly important when
18 they show up in a contract later. So we are
19 particularly interested in what you have to say. We're
20 not building these RFPs in the dark anymore. They're
21 wide open. We get a much better product when we have
22 industry input. I think we get a much better price,
23 and hopefully we get a much better quality for our
24 beneficiaries in terms of delivering a quality dental
25 benefit.

1 I thought I'd take just a second just to give
2 you the lay of the land a little bit in terms of where
3 the TRICARE management activity has been for the last
4 few years and what we're doing right now, and again,
5 how the value of an industry forum plays in this.

6 We have, as I mentioned, completed about a
7 \$32 billion dollar acquisition cycle that involves the
8 contracts that you see listed on this slide. For those
9 of you that are familiar with our business under our
10 current contracts that are in existence today, we
11 manage all of the TRICARE program through seven managed
12 care support contracts. Under TNEX, we decided to take
13 a look at that and see if there was some value in
14 carving out any of those contracts to put out an RFP
15 that might target a particular piece of industry and
16 give us a contract that might be a little easier to
17 manage and (inaudible) a better price. And that starts
18 with the first one you see up there.

19 TRICARE dual eligible fiscal intermediary
20 contract is a nifty little term somebody came up with.
21 Basically it references our TRICARE for life benefit in
22 the over 65 for the most part, although there are some
23 under 65 in that. That contract actually starts on
24 Thursday of this week in the first start up in Region
25 11. So you can see we are well down the road as it

1 relates to TNEX and the start ups.

2 The next three used to be the seven managed
3 care support contracts. It's now three managed care
4 support contracts. One each for the north, south, and
5 west. Our first start up here is in June. We don't
6 plan any major changes to this particular acquisition
7 such that you have seen up here, unless, of course, we
8 get some good ideas here today that take us in a little
9 different direction.

10 Retail pharmacy, third on the list there was
11 carved out at the managed care support contracts. That
12 is a single national contract, has one single start
13 date, and that's June 1 of this year. So again,
14 another huge undertaking for us.

15 Marketing and education basically this is all
16 our marketing materials. All the presentations that we
17 would use in our town hall meetings, (inaudible) with
18 beneficiaries and providers. We made the decision to
19 carve that out of our contracts so we can go out with a
20 single voice, a single look and feel to all our
21 contractors. I appreciate any comments you may have
22 today regarding marketing and education and how it
23 plays into this particular RFP.

24 NQMC is our national quality monitoring
25 contract. Maximus was the winner of that contract.

1 That one stands up I think in April, if I remember
2 correctly. Basically that keeps us honest. Those
3 folks bring to the table peer review activities on all
4 our managed care business and all our denials and
5 pre-authorization that may have been denied, samples of
6 claims to make sure that the proper adjudication
7 decisions were arrived at. These folks also support
8 our teams and hearings.

9 And last but not least, is the contract we
10 just awarded a few weeks ago for claims and audit
11 contract under our managed care business. We audit on
12 a monthly and quarterly basis all our med surg claims
13 and in pharmacy claims for not only payment errors but
14 what we call occurrence errors. Meridian Resource
15 Corporations won that. Actually they have been our
16 contractor since 1994.

17 I put this up here just to give you kind of
18 the lay of the land for where we're at for those of you
19 who are not familiar with TRICARE business and TMA.
20 This industry forum we're having today may be the last
21 for several years for our program as this will complete
22 what has been a huge procurement cycle. Every one of
23 these contracts started out with an industry forum
24 where we sat down and try and hear what you all thought
25 about the business that we're in and what makes sense

1 in terms of what should be in that RFP.

2 Today, as we go through the agenda, and Gene
3 will talk you to more about that in a little bit, but
4 we're particularly interested in your thoughts around
5 our benefit packages in keeping up, are there better
6 ways to do things. Also, we're interested in
7 procedures, what can we put in this current contract
8 that would make it simpler for you to bid on. What
9 represents state of the art, if you will. Give us some
10 things to sit back and take a look at. We have built
11 time into this schedule to certainly allow for that.
12 And hopefully make our lives all a little bit easier in
13 terms of deadlines, which we all get faced with through
14 the acquisition.

15 With that, before my voice completely goes, I
16 want to thank all of you for being here. And I thank
17 you in advance for your input in this forum, and I wish
18 you all well in the bidding process. Thank you.

19 MR. MAYS: Thank you, Brian. I want to just
20 go over the agenda briefly here as to what we're going
21 to do and a few administrative items. Many of you have
22 been here before so probably know that the telephones
23 and restrooms are to your left around the corner here
24 if you need those. I'd like to let you know that this
25 is being recorded, and there will be a transcript

1 available probably within a week to ten days that we
2 will post on the website for you to review.

3 Questions, we have some microphones in both
4 isles, and we ask that you go to the microphone if you
5 have a question and state your name for the record.
6 And we do encourage you to use the microphones so that
7 the reporter can hear the questions as well as the
8 panel up here in the front.

9 Mr. Rubin already identified our panel here,
10 so we'll skip that one. I will state that we'll have
11 Lynn Head do a brief synopsis of what the current TDP
12 program consists of just so everybody has a baseline to
13 compare against. Then we'll have Colonel Concilio and
14 Allen Edwards talk about what our plan benefit is, and
15 encourage some comments and input from you folks to
16 help us figure out if we're going in the right
17 direction or changes we need to make.

18 We have a few objectives here for the forum
19 of what we want to do. Commercial benefit structure,
20 we want to look at that, are we going down the right
21 pathway that you're going down? Cost structures,
22 networks, how do we build a network? Where can we
23 build a network? The different structures and
24 standards, and some of the things we want to get at
25 here are when we're looking at the benefits or networks

1 or if we're different from where industry is, is that
2 all based on a cost (inaudible) factor? Have the other
3 numbers changed for business, or is it based on new
4 health data? Have the health patterns changed or
5 health processes or the science or technology changed?
6 We'd like to get at that so we have a better way and
7 better determination of what our benefits should be.

8 This is basically the path we're going to
9 follow this morning. Marjorie will be up here in a
10 couple minutes to go through some contracting issues
11 with you. Lynn will do the overview. And then we'll
12 get into the benefit discussion to help determine what
13 the benefit will be.

14 We do ask that you constrain your input, your
15 comments, your questions to benefit and in helping
16 figure out what our benefit should look like. There's
17 a lot of things I know you will be interested in as far
18 as how the RFP is being put together, and that's
19 something we'll get at in a few months when we do the
20 pre-proposal conference, which I'm sure you're all
21 eagerly awaiting. (Inaudible) benefits going to be and
22 help us put that together. So if there aren't any
23 questions, I'm going to turn this over to Marjorie.

24 MS. WATSON: Good morning and welcome. We're
25 really glad that you're here. We want to -- I just

1 want to reiterate and say again to those who actually
2 sent in your input and answered our questions, we know
3 they were voluminous and many, but we really appreciate
4 the input, and it's going to be very beneficial to us.
5 So I want to take the time to make sure that I thank
6 you for coming in to the forum today, and also for what
7 you've already done, which was quite a bit of work
8 already. And like I said, we want this to be a
9 successful industry forum.

10 We want you to feel very free to dialogue
11 with us and to really pour input into us. This is
12 about the only chance we get where we get a chance for
13 you all to talk to us. And so I just wanted to thank
14 you.

15 In general, the details of our requirements
16 right now are not yet firm. Out on the website, I know
17 you saw the TDP requirements, but they're not firm.
18 They're not etched in stone. This is where we are
19 right now, which is why we're here at this forum today.
20 So the details are not -- they are not firm. So like I
21 said, we can take things into advisement, and what I
22 call a living document. It's living right now, so we
23 want you to know that.

24 Now we're seeking industry input. That's
25 what we want from you today. That's why we're here

1 today. Your participation in the forum, as it has been
2 in terms of questions and the things that you all have
3 been submitting is totally voluntarily. No one is
4 making you come. We appreciate the -- it's voluntary.
5 So it's voluntary.

6 The information mentioned during forum --
7 this forum today and anything that has been submitted
8 so far does not obligate the Government or you as the
9 contractor in any manner as it is all open. We also
10 ask that we do no side bar discussions. We don't want
11 to be cornered, or we don't want to corner you to
12 discuss things. We want everything to really be
13 presented right here in this forum where they are
14 taking down everything. And so we just really would
15 like to have no side bar discussions as we -- I was at
16 a base at (inaudible) and they had a -- one time they
17 had a sign that says, what you see, what you hear, when
18 you leave, leave it here. So we would like you to
19 really input everything into this forum today.

20 The Government is looking for open dialogue
21 between the Government and industry during and after
22 the forum. There will be a lot of discussions going
23 on. This is not the end. That's why we're going to
24 make sure we get the information out. So we want to
25 have it now, and we want to continue that forum to come

1 forth.

2 Also, we're asking that any comments that you
3 may have that you submitted via e-mail at our website,
4 it is, as they tell me, live. I like that. And
5 there's our website address down there at the bottom.
6 That comes directly into my mailbox, and I make sure
7 that it's disseminated. So if you have anything that
8 you want to know, this is the place to go. As we know,
9 we make phone calls, but we're not always there. So
10 this is the tool we'd like for you to use.

11 Right now, as we're -- we're putting this
12 together, we're looking at a competitive negotiated
13 acquisition in accordance with the Federal Acquisitions
14 Regulations, FAR 15, which is a little different from
15 the current contract which is commercial. This also
16 opens us up to our source selection process, which
17 gives us an opportunity to really evaluate all the
18 information. It minimizes the complexity of the
19 solicitation. We'll be able to do a lot of things a
20 little more flexible than what we used to do.

21 We're anticipating our anticipation for the
22 fixed price contract award. Also, we intend to award
23 from the initial proposals. In other words, what you
24 send in the first time, make it your best. Make sure it
25 has everything in there that you would want us to

1 consider. So we're looking at awarding from initial
2 proposals.

3 I wanted to talk briefly about performance
4 based specifications. This is a requirement. This
5 will be a performance based type contract. In other
6 words, we're focusing now on the outcome. We're
7 focusing on result, not the methods of performance or
8 the processes. We're trying to get out of the business
9 of telling you how to do it. We want to know how
10 industry does it. So what you want to do is a very
11 brief 30-40 pages, but we want -- we want to tell you
12 what the results are, and you tell us how it's going to
13 be done. This also gives you -- as a contractor,
14 you'll have more latitude, more flexibility in
15 determining the method of performance. This is what
16 you do every day. This is your industry. Let us know
17 how you want to do it.

18 Also, maximize contractor control of the
19 work, the processes, and allow for innovation and
20 approaching various work requirements. In other words,
21 everyone can do their own innovations in accordance
22 with what we're asking for. (Inaudible) performance
23 based is really a good way to go. I administered many
24 performance based type contracts, and like I said, it
25 really makes for excellent input when it comes to you

1 all preparing your proposals and things of that nature.

2 And with that, and I was telling you, is I
3 was going to be brief and be seated if there are no
4 questions.

5 MS. HEAD: Good morning. I am Lynn Head.
6 I'm the current Contracting Officer's Rep on the TDP.
7 I've had the opportunity to work on all but the first
8 two dental programs that were put into place here at
9 TRICARE Management Activity. Today, I'm going to give
10 you a brief overview of our current program just to
11 give you an idea of what we're doing today. I know
12 most of you were here five years ago when we were
13 putting this one together. So with that, I'll just
14 begin.

15 I've given you the basic background on this.
16 The authority, Title 10 of the US Code, Chapter 55,
17 Section 1076A. Our regulation is 32 CFR 199.13. And
18 our current contractor is United Concordia Companies of
19 Harrisburg, Pennsylvania. The contract period is
20 February 1 of '01 and will continue through January 31
21 of '06. We are currently in the fourth option period
22 which has just began the first of February.

23 TDP, as you heard earlier, is put out as a
24 commercial-buy contract. It was competitively awarded.
25 Is it group indemnity dental insurance program. It is

1 continuous open enrollment, and it is clearly
2 voluntary. Contract performs enrollment and premium
3 collection process under this current program, which
4 was a first for our dental programs here. This is a
5 major one. We did -- we tested this with the reserve
6 and retiree programs. And based on those, we brought
7 it to this program, and it is has improved the way
8 operations are going. It isn't without it's stumbling
9 blocks, but we are in program for it. New enrollments
10 do require a one month pre-payment with the
11 application. This is to start the enrollment and also
12 to get the premium deduction process in place.

13 Geographical areas of coverage for this
14 program, we have the CONUS and OCONUS areas. CONUS
15 being the 50 United States, the District of Columbia,
16 Guam, Puerto Rico, and the US Virgin Islands. Our
17 OCONUS service area is broken into remote and
18 non-remote areas. And as you see from the slide,
19 (inaudible) OCONUS area. We are worldwide.

20 The definition for remote is, there is no
21 fixed uniform service dental treatment facility
22 available or one that --or there is no part-time DTF.
23 Our non-remote, we do have fixed DTFs OCONUS. Our
24 dental benefits coverage, I think we have one of the
25 most comprehensive packages out there. We do cover

1 over 200 procedures, including the diagnostic,
2 preventative, restorative, endo, perio, prosthodontics,
3 oral surgery, and orthodontics. We have no waiting
4 periods or no deductibles under this program. The
5 annual maximum was raised to \$1,200 under this program
6 as was the lifetime orthodontic maximum went up to
7 \$1,500.

8 Provider networks and access to care. This
9 contract does require to have a network in place. And
10 with that, our beneficiaries not balanced bill for
11 coverage services when they go to our network
12 providers, we require the network provider to be
13 reimbursed at a prevailing charge sufficiently above
14 the 50th percentile for a particular region to
15 encourage participation in the network.

16 Our access standard is really what drives the
17 size of our network and as such, it requires an
18 enrollee to obtain an appointment within 21 days and 35
19 miles of their residence.

20 These are the current performance standards
21 that applied to the TDP. Claims we cover from one to
22 14 days at 90 percent. Claims 15 to 30 is 98, and then
23 up to 60 days we expect them to have 100 percent
24 completion at that time. Routine correspondence we do
25 have, as the chart shows you, the different time frames

1 there, anywhere from 85 percent to 100 percent within
2 45 days. Reconsideration finalized, we allow a 31 to
3 60 day period at 90 percent, 61 to 90 at 98, and 91 to
4 100 we expect 100 percent to be completed. Telephone
5 activity we require that 90 percent of the calls are
6 serviced within the first 30 seconds. This is a live
7 body. Enrollee satisfaction we are requiring an 88
8 percent satisfaction rate under this program.

9 Currently, we have approximately 45,000 general
10 dentists in the network and an additional 10,000
11 specialists.

12 Eligible populations. Under this program, we
13 added additional populations. We've also had active
14 duty family members, and with this program we
15 (inaudible) selective reserve program in -- to the TDP.
16 But in addition to that, we added the individual --
17 excuse me -- individual ready reserve members and their
18 eligible family members. So we -- just so you
19 understand, it is the family members of all the
20 selective residents and the IRR populations.

21 The defense eligibility and enrollment
22 reporting system, better known as DEERS, is the sole
23 source for verifying eligibility for the TDP program.
24 DEERS is also our database of records for enrollment in
25 the TDP. Eligible and enrollment/disenrollment

1 functions are performed online real-time to the DEERS
2 system.

3 Our enrollment types, we actually offer two.
4 You either enroll as a single member or a family
5 member. A single is either one eligible family member
6 or the select resident or guard member themselves.
7 They enroll separately for themselves. Family members
8 or two or more covered eligible family members in the
9 unit, and we have -- and I'll touch on it a little bit
10 -- survivor programs that we have.

11 Enrollment does require (inaudible) or a 12
12 month lock-in. Previously it required 24 months time
13 of service to be able to enroll in the program. And
14 with this one, we've also added a 12 month lock-out for
15 disenrollment. Other than a valid reason. This can be
16 failure to pay premiums is one of the bigger ones at
17 this point, since we did add a direct billing option
18 under this. And for this program we did add a
19 contingency enrollment lock-in waiver for our reserve
20 guard family members when a member is called down for
21 duty for greater than 30 days. Since 9/11, this has
22 really been something -- a great benefit that we did
23 add in here for our reserve members.

24 Survivor benefit. This is for when our
25 enrolled family members of an active duty sponsor dies

1 while on active duty orders for greater than 30 days.
2 They will continue to receive TDP benefits for up to
3 three years. And the Government does pay 100 percent
4 of these premiums. We've had two payments for survivor
5 benefit under the life of the current program. NDA of
6 '03 expanded a benefit for one to three years. And the
7 FY04 expanded it to include families members who have
8 been previously enrolled in the program but were
9 transferred to a duty station where care was available
10 either at the DTF. This mainly applies to those that
11 were OCONUS because there was readily TDF available to
12 them. The OCONUS does augment the care in the DTF, so
13 they are now part of this process.

14 This is our current enrollment numbers as per
15 our DEERS database for the month of February. Sorry
16 these wires tend to get in the way sometimes. Sponsor
17 plans we currently have, and this would be our reserve
18 sponsors not on active duty. We currently have
19 approximately 37,000 in that category. Our individual
20 plans, we have 188 -- 187,000. Family plans, we have
21 441,000. And individual survivor plans, currently at
22 289, as with our family plans is up to 644. This is --
23 unfortunately, these numbers continually increase every
24 day as we continue in our war.

25 Non-Government plans. As I said earlier, we

1 did add the selective reserve family members and IRR
2 members. Under the IRR, we actually have two
3 categories. We have those that are considered to be
4 special mobilized and there's a non-mobilized. If
5 you're in a special mobilized category, (inaudible)
6 60-40 premium sharing plan as do the active duty family
7 members. When they're not on active duty, these the
8 (inaudible) family member take one percent of their
9 premium, and right now we have approximately 22,000 in
10 that category. The special mobilized program hasn't
11 kicked off as well as was anticipated. However, we do
12 have three families that are in the program with that.
13 And then our IRR non-mobilized, we have a little over
14 2,000 that are participating in that program. So for a
15 total of the month of February, we have 690,000
16 enrolled. And that's plans, it's not covered lives
17 assuming it is based plan. And as such, our covered
18 lives, we have approximately 1.7 covered lives in the
19 program.

20 Premium collection process. Again, this was
21 new to this contract. Contractor does draw the premium
22 collection of the sponsor shares of the monthly
23 premium. The Government share is collected by the
24 Uniform Finance Center if pay is available. If not,
25 then we have a direct billing option under this

1 contract for the provider -- excuse me, the contractor
2 will direct bill a member for their monthly premiums.

3 These are our current premium rates for
4 option period 4 and into option period 5. Again, it's
5 by -- it's a -- I'm showing you these are the ones that
6 the Government participates in. Enrollee share for
7 single is \$9.07, and the Government 60 percent is
8 \$13.61. And the total premium rate is \$22.68. For the
9 option period 5, (inaudible). For our survivor plans,
10 the Government is picking up 100 percent of the
11 premium, which is your total line on these charts.

12 And with that, I will turnover to Colonel
13 Concilio.

14 COL. CONCILIO: I see we're ahead of
15 schedule. Are there any questions pertaining to any
16 information that has been delivered so far, which is
17 the main focus of this industry forum? If not, I'll go
18 ahead and start. As you all probably realize -- I'm
19 sorry, can you please go up to the podium.

20 MR. MATZKE: Sure. My name is Mark Matzke.
21 I had a question on the slide when you talked about
22 provider networks and access to care. Specifically the
23 third bullet point.

24 COL. CONCILIO: Which slide was that?

25 MR. MATZKE: Slide 17 please.

1 COL. CONCILIO: State your question.

2 MR. MATZKE: The third bullet, the network
3 providers are reimbursed at a prevailing charge
4 sufficiently above the charge sufficient above 50th
5 percentile for a region to encourage participation. Am
6 I to assume that basically when they bill contract with
7 network providers, that they're paying them basically
8 more than what the most frequently charged procedure is
9 for that area?

10 MS. HEAD: Unlike on the medical side, we
11 don't have the volume that we send any particular
12 dentist. And so with that, we encourage the contractor
13 to reimburse at a rate higher than what the 50
14 percentile is that for particular region. In other
15 words, whatever your peers -- the peers are doing at
16 that point, the 50 percentile, we encourage the
17 reimbursement level to be higher than that in order to
18 encourage participation in the TDP network. We're
19 asking incentive for providers to join the network, and
20 this is how it's done.

21 MR. MATZKE: Do you know what the basis for
22 the 50 percentile is?

23 MS. HEAD: No. I don't.

24 MR. MATZKE: Thanks.

25 COL. CONCILIO: Any other questions on the

1 previous discussion? As I said, the benefits
2 discussion is the main portion of this industry forum,
3 and we would like a free discussion with our
4 participants in industry on questions which we have
5 already posed on the website. And we have gone ahead
6 and got responses from several industry participants
7 already, and we consolidated those responses as you can
8 see on the slide. The responses that -- the consensus
9 opinion that we've already received is green on the
10 slide. And we have some follow up questions on this
11 (inaudible) between (inaudible) red on the slide.

12 And for the first area of discussion, we are
13 going to talk with diagnostic and preventive services.
14 And just as a whole, since many of these procedures are
15 done together, we've gone ahead and we've asked what
16 was industry standard for coverage and plans regarding
17 oral evaluations, oral prophylaxis or dental
18 (inaudible), and top fluoride applications. And
19 consensus, I think, from everyone was that it's too per
20 one-year period. But along those lines, we would like
21 some feedback from industry on how that industry
22 standard is developed, if you see any changes, what do
23 you think are the main drivers behind why that standard
24 is two per year, or if you see any changes regarding --
25 for instance with fluoride applications, is there any

1 kind of age limitation or if you would have a maximum
2 age? And please feel free to come to the mic and give
3 me your thoughts on that.

4 MR. LESLEY: My name is Craig Lesley.
5 Specifically on the topical application of fluorides as
6 in the commercial market, we are frequently seeing age
7 limitations on that particular benefit as science and
8 some historical claims information help us identify the
9 advantages or disadvantages over a certain age. So we
10 frequently see age limitations of age 14, and sometimes
11 see age limitations of 19. 19 is convenient because
12 there's a lot of eligibility provisions in commercial
13 contracts that affect full-time coverage for attendance
14 that ends at age 19. So there's more administrative
15 (inaudible) for age 19 than scientific reasons. If we
16 go strictly scientific, essentially once a child has
17 his or her permanent teeth, then their dental future is
18 pretty much established, and the advantage of fluoride
19 rapidly declines.

20 COL. CONCILIO: I was wondering if there's
21 any indication from industry whether there's evidence
22 based care to be a driver of this or if it's provider
23 expectations or --

24 MR. LESLEY: There is definitely scientific
25 studies available that would support that age 14.

1 COL. CONCILIO: Do you see at this point any
2 trend in industry to change the industry standards in
3 that area?

4 MR. LESLEY: Just based on the science and
5 based on the cost (inaudible) beyond that age.

6 COL. CONCILIO: Has it occurred at this
7 point, or do you see it occurring in the near future?

8 MR. LESLEY: Yes. It is in place in
9 contracts that we see today that I administer.

10 COL. CONCILIO: And as far as along those
11 same lines since maybe (inaudible) previously zoned
12 standards, are there any changes coming that you see as
13 far as dental exams or dental prophylaxis also to limit or
14 change the number of done per year from your point of
15 view?

16 MR. LESLEY: We see discussions on it, but no
17 change at this point.

18 COL. CONCILIO: Do you think that's a
19 beneficiary expectation that's currently driving
20 standard, or is it professional organizations that's
21 the drive, or what do you feel is the main function?

22 MR. LESLEY: I would answer all of the above.
23 The relationship between a dentist and a patient is
24 stronger than some of us realize. And they -- the
25 dental profession is pretty good sending out postcards

1 and getting people in on a regular basis. And I think
2 oral health has improved as a result. The question that
3 could be reasonably asked is, given that improvement,
4 is it -- do we need to maintain the same levels going
5 forward with a healthy dental population that we
6 established in the past to get people that healthy.

7 Then it also depends on the population.
8 There maybe -- this population may have a different
9 oral health status than another group. So I think the
10 answer is, that it's good that you're asking these
11 questions, and the answer is really it depends on the
12 population that you're serving just because it's one
13 way on the east coast doesn't mean it is on the west
14 coast.

15 COL. CONCILIO: A corollary to that might be,
16 do you really think that people utilized two of these
17 procedures per year generally?

18 MR. LESLEY: Oh, yeah.

19 COL. CONCILIO: So not only it's offered,
20 they actually do use them?

21 MR. LESLEY: Yes.

22 COL. CONCILIO: They do come to the dental
23 office and receive their two (inaudible)?

24 MR. LESLEY: We have a goodly percentage of
25 them do, and that's very clear in the data. However,

1 it is also, given the CDT codes that we're all using to
2 administer claims, that there is a clear distinction
3 between an exam, a cleaning, and fluoride. So you
4 could easily have a different age limitation or
5 frequency on fluoride than you do on other benefits.
6 It would be relatively easy.

7 COL. CONCILIO: Along those lines too, do you
8 see if they're looking at a dental cleaning versus a
9 dental prophylaxis versus cleaning for a perio patient,
10 do you find different providers within that dental
11 office providing certain procedures? Do you see the
12 hygienist doing certain things that -- in some states
13 -- a dental assistant may be allowed to do certain
14 procedures?

15 MR. LESLEY: For the diagnostic -- not for
16 the diagnostic, that's the purview of dentist. But for
17 the other preventative services, the office staff,
18 probably licensed, delivers the vast majority of that
19 care over -- but -- if the person is licensed, whether
20 a hygienist or assistant, they're certainly qualified
21 to provide that coverage.

22 As it relates to periodontal prophylaxis
23 however, that is an area that deserves a lot of
24 attention because typically that will only be a value
25 to the patient if they have prior history of

1 periodontal treatment. So that might be something to
2 consider a historic periodontal treatment with the
3 allowance of a periodontal prophylaxis.

4 COL. CONCILIO: Also, do you think that most
5 dental offices, or from utilization patterns, do you
6 see that routinely fluoride is always done in
7 conjunction with a dental prophylaxis on most or every
8 visit?

9 MR. LESLEY: No. It's not routine, no.

10 COL. CONCILIO: Does anyone else have some
11 thoughts along this line? I know we have some public
12 health dentists in the audience. Do you have any
13 thoughts as far as what you feel the necessity or
14 anything as far as whether some of these things should
15 be done or if there's an age limitation on anything as
16 well?

17 I think the following question last here
18 appears, should we maintain these standards or reduce
19 the frequency of some of them? What are your thoughts
20 on that now that we've more or less seen utilization
21 patterns? Anybody have comments on that with industry?
22 So I take that to mean that two per year of each of
23 these types of procedures is probably the way that
24 industry is planning to go at least in the foreseeable
25 future? Thank you.

1 Next slide is regarding radiology services.
2 We just wanted to get your ideas on commercial plans.
3 Obviously there are some dental offices that are not
4 equipped to offer certain types of radiographs, and
5 sometimes these have to be done at outside radiology
6 labs or sending the patient back. Do you see that
7 referral -- responses from industry obviously --
8 responses were mixed, and it doesn't seem overall that
9 this is done that frequently in dental offices. But do
10 recommend this in the next program, or do you see any
11 reason to even consider it from our point of view? Any
12 comments from industry on that.

13 MR. HARBOLD: I'm Tom Harbold, United
14 Concordia. And in terms of your question, my
15 recommendation would be against providing coverage for
16 x-ray by radiology labs. I don't think it's a big
17 problem in the program today. We do get the occasional
18 plan or inquiries about that. I think there are other
19 ways that it can be dealt with. And I'd have concerns
20 about getting a bill from a laboratory for taking the
21 x-ray and possibly a (inaudible) charge from a treating
22 dentist for interpreting that x-ray or making some type
23 of treatment decision from it. So I think you're
24 opening an area I'm not really sure you want to get
25 into.

1 MR. DAWN: I'm Lowell Dawn. Tom and I
2 disagree on this one. Our experience traditionally
3 with radiology practice is separate from restorative
4 dental practice show typically that you're getting at
5 least comparable service, if not better. Most of the
6 agreements I venture would be (inaudible) for sure does
7 not allow the dentist to submit a separate charge for
8 radiographic interpretation.

9 COL. CONCILIO: So your charge is only for
10 the taking of the radiograph itself?

11 MR. DAWN: And the interpretation would go
12 along with that.

13 COL. CONCILIO: From?

14 MR. DAWN: From the radiology practice.

15 COL. CONCILIO: Are these specific types of
16 radiographs, or are they types that maybe an oral
17 surgeon would not always have access to in their
18 office?

19 MR. DAWN: They certainly could be surgical
20 related, orthodontic related, or if somebody is going
21 in for one particular exposure, they probably would
22 have migraines and everything else done there at the
23 same time.

24 COL. CONCILIO: Do you recommend, along this
25 line, that there should be some type of coverage for

1 this particular type of procedure that would be a by
2 report procedure?

3 MR. DAWN: Well, it certainly could be by
4 report. Although, for the most part, our experience
5 will tell us that film exposures are traditional. They
6 might be offered in the provider's office, or they
7 might be referred out to a radiology lab.

8 COL. CONCILIO: But if they were referred out
9 to a radiology lab, would you consider that a by report
10 decision.

11 MR. DAWN: Probably not. Our experience
12 could show that the charges are comparable. The
13 services rendered are comparable. They're just being
14 done in a different location.

15 COL. CONCILIO: And I assume too that there
16 has to be -- an interpretation there had to have been a
17 reason why it was not done in the dental office itself?

18 MR. DAWN: Not necessarily.

19 COL. CONCILIO: Any other comments on this
20 topic? Next slide please. Question of sealants has
21 come up many times. So we wanted to get some input
22 from industry regarding the maximum age for sealant
23 coverage. And a variety of responses we got were all
24 within the range of 13 to 16 years old currently and
25 present standard, as you may as well know, that we are

1 covering bicuspid, and it is up to 18 years of age.

2 And it seems as though the industry standard, from my
3 interpretation of these responses, that a lower age
4 would be acceptable.

5 And also another question regarding bicuspid
6 as being eligible teeth for sealants? Overall, if we
7 eliminated it, (inaudible) responses they wouldn't see
8 any problems if we did that. Along that line, we pose
9 a question here. Would the forum participants agree
10 that 14 years of age would take a minimum age of 13 and
11 16 be a reasonable maximum age for sealant coverage?
12 And any comments regarding bicuspid as far as whether
13 you cover them or not covered them and any reasoning
14 behind that?

15 MR. LESLEY: I will just -- Craig Lesley
16 again. I would suggest that there is linkage between
17 my comment on fluoride and age limit of around 14 that
18 we would suggest for sealants if sealants were
19 continually covered. The scientific basis is the same,
20 and that is just trying to prevent cavities during the
21 developmental stage.

22 COL. CONCILIO: Do you see any trend for
23 coverage of molars to an older age, late teens, but
24 still elimination of bicuspid?

25 MR. LESLEY: No. In fact, sealants is a

1 coverage in a minority of commercial plans, not a
2 majority of benefits. And again, this would be a study
3 that we could make available to you in the very near
4 future. But our analysis of over millions of claims
5 has indicated no difference in the incidents of care of
6 sealant coverage or no sealant coverage.

7 COL. CONCILIO: And also along those lines,
8 do you see that if you did cover sealants either to a
9 later age or including bicuspid, is there a
10 (inaudible) utilization over any of those types of
11 procedures?

12 MR. LESLEY: Yes.

13 COL. CONCILIO: Without additional benefit?

14 MR. LESLEY: Either way.

15 COL. CONCILIO: The second part of that
16 questions is, what is industry standard for cost shares
17 for sealants. And the varies responses was no cost
18 share up to about a 20 percent cost share. So our
19 question is, where do you think we should go with this?

20 MR. LESLEY: As long as I'm here, and as long
21 Dr. Dawn doesn't tell me to sit down, we generally --
22 if sealants are covered, we would encourage or we do
23 encourage our clients to spike them out of a diagnostic
24 or preventative areas which are the higher copayment
25 from 100 percent claims, and drop them into some

1 convenient other location in the plan that would have
2 some lower copayment percentage. So -- the purpose
3 being, that it's convenient, is forces from the
4 discussion between the patient and the provider in
5 terms of the appropriateness (inaudible).

6 COL. CONCILIO: What's your recommended
7 co-pay if there is one?

8 MR. LESLEY: It would be 20 percent.

9 COL. CONCILIO: Other comments on sealants
10 and utilization package? Do you think they, as a hole,
11 kind of over utilized procedures, appropriately
12 utilized as far as preventative type measures? What
13 are your thoughts?

14 MR. LESLEY: I think there's some degree of
15 over utilization. I think it tends to be provider
16 specific. I think there are a number of providers that
17 do use some degree of judgement, make decisions based
18 on the patients situation as to the value of placing
19 sealants in specific instances, but there are no
20 questions that there are a fair number of providers
21 that place them routinely without using a -- I should
22 say using very little judgment is my sense. So I think
23 it does promote some degree of over utilization, but it
24 tends to be provider specific.

25 COL. CONCILIO: When they tend to place them

1 routinely, are they placing them on molars or bicuspid
2 or both?

3 MR. LESLEY: Since you wrote the program
4 coverage to bicuspid, the tend to do them all.

5 COL. CONCILIO: Any other comments on
6 sealants? Most of your composite restorations seem to
7 be more and more utilized (inaudible). However, we
8 wanted to know whether there is a current industry
9 standard considering posterior composite resins as a
10 covered benefit. Even though we know that civilian
11 practices use them, up to now, our perception is that
12 many plans do not cover them as a covered benefit. And
13 responses we got more or less confirm that thought, and
14 that they said you usually pay as an alternative
15 benefit to amalgam.

16 Given that these types of restorations are
17 being utilized along the lines of civilian practices,
18 what do you think industry is doing as far as where
19 these are going over, for instance, the next five or so
20 years? Do you think that they're going to be covered
21 procedures as opposed to alternative benefits? And
22 this is something I would definitely like some thoughts
23 from industry on.

24 MR. LESLEY: Craig Lesley again. The
25 percentage of the data that we see and the percentage

1 of posterior composite resins being delivered compared
2 to the traditional amalgam, appears to be crossed in
3 literally the same number of ones being provided as the
4 other. And the reason that we see, from our
5 perspective for that, is a fairly rapid improvement in
6 the composite resin materials themselves and some
7 longitudinal study that are indicating that unlike the
8 early form of resins that didn't last as long, the new
9 science seems to allow the new resins to last almost as
10 long as an amalgam.

11 They are more expensive for some reason, and
12 they are more difficult to put in a tooth, using a non
13 dental term. But they are popular, and they do tend to
14 last now. And so from a quality stand point for
15 restoring the tooth and for the benefit of the member,
16 there's probably no difference especially if you're
17 looking during -- for the period of contract we're
18 discussing today.

19 COL. CONCILIO: And the question that I would
20 like answered, along those lines, as you indicate,
21 posterior resins materials themselves have improved
22 greatly over the last several years, although they are
23 still quite technique sensitive, do you find that you
24 have to replace them more frequently than amalgam?

25 MR. LESLEY: No. There -- the dentists who

1 are doing them know the techniques. And if it goes in
2 right, it stays in. Just like amalgam, for the
3 amalgam, if it goes in wrong, it won't last more than a
4 year and you'll be in having that done right
5 (inaudible).

6 COL. CONCILIO: Why are -- from the answers
7 we received, why do we still see this as an alternative
8 benefit to amalgam rather than a covered benefit?

9 MR. LESLEY: I would submit that there are
10 two reason. One is purchaser's reluctance to change
11 anything. It's just what it always has been. And the
12 other is with the other health care costs going up,
13 or medical hospitalizations or drugs, that by the time
14 you get around to dental in the commercial industry or
15 commercial side of the business, there just isn't any
16 money left over for more expensive benefits. And the
17 resin or composite restoration is slightly more
18 expensive, (inaudible) to the Government, and it is
19 more than likely to (inaudible) an alternative benefit
20 in those situations where the large groups where the
21 employer or plan sponsor is determining benefits to
22 this specific level.

23 COL. CONCILIO: Do you find from industry
24 perspective (inaudible) to be including that in more
25 plan health covered benefits with a set cost share, as

1 a cost share comparable to amalgam for instance?

2 MR. LESLEY: It's becoming more common in
3 off-the-shelf programs. So if plans aren't specifying
4 the type of plans that are seen, the dentists are doing
5 them more frequently as the other. The science is
6 showing they will last, so why not go ahead and include
7 it at the same cost share that any other restoration
8 would be covered, so they don't differentiate in the
9 cost share. It's a restoration, and if it's one or the
10 other either way, it would be included. In this case,
11 a 20 percent cost share.

12 COL. CONCILIO: So in most cases amalgam is
13 20 percent cost share (inaudible)?

14 MR. LESLEY: You wouldn't differentiate one
15 type of basic restoration from another type of basic
16 restoration in the cost share percentage.

17 MR. (Unidentified): I would tend to agree.

18 COL. CONCILIO: State your name, please.

19 MR. (Unidentified): I think our experiences
20 today that most programs still treat them as an
21 alternative benefit, but there's certainly a move in
22 the direction of groups adding coverage for composites
23 in and of their own right.

24 I think one of the things that sort of
25 underlies and perhaps your question in terms of whether

1 they should be a covered benefit, I think there's a
2 presumption that when you treat them as an alternative
3 benefit, that the patient is making an informed choice
4 knowing that if they select the composite, there's that
5 willingness to pay the difference. I think in a lot of
6 offices, they don't really make an informed choice.
7 The doctor makes the decision. Some dentist, the only
8 type of composite restoration they provide is composite
9 restoration, and the patient is basically stuck with
10 that.

11 When you treat it as an alternative benefit,
12 that means they pay not only the 20 percent of the
13 amalgam allowance, but they also end up picking up the
14 difference between the amalgam allowance and the
15 doctor's charge for the composite. That's the
16 situation in the program today. And I suspect that's
17 the situation with all of the groups that provide
18 coverage as an alternative benefit.

19 COL. CONCILIO: If we have the choice of
20 covered benefit versus alternative benefit, is there
21 any problem as far as whether the patient will be put
22 in the position, not of choice, but if the office
23 decided to go ahead and offer a composite, that the
24 insurer would revert back to an amalgam benefit instead
25 or pay that rate if there are different payment rates?

1 MR. (Unidentified): I think you would find
2 that the payment -- the allowance would be more for the
3 composite than it would be for the amalgam. I would
4 agree that you should have the same cost share or
5 co-pay, whether it's amalgam or composite. So the
6 patient will have a slightly higher co-pay in terms of
7 just pure dollars with a composite than they would
8 amalgam, but that's probably less than what their
9 out-of-pocket cost would be today.

10 And I'm not sure I understood your question,
11 but to go back to the question on the board, I would
12 provide coverage for composite restoration in and of
13 their own right in the next program.

14 COL. CONCILIO: So you have an amalgam
15 coverage benefit and a posterior composite resin
16 benefit as opposed to an alternative benefit?

17 MR. (Unidentified): Yes. I would.

18 COL. CONCILIO: At the same equal cost share?

19 MR. (Unidentified): At the same cost share
20 percentage.

21 MR. LESLEY: I'd like to -- Craig Lesley
22 again. I'd like to supplement my comment because it
23 seems to be important for TRICARE to be careful in this
24 change. And I would support that this makes sense
25 given the time frame. But there is some bad science

1 right now. I officially say the science is being
2 (inaudible) above the amalgam restoration itself. So
3 you would want to make sure that there was some
4 protection in the plan that perfectly healthy, safe,
5 functional amalgam restorations in place today were not
6 removed and replaced with the restoration based on bad
7 science. American Dental Association and a number of
8 other Government agencies are looking into the mercury
9 content of amalgam restoration.

10 COL. CONCILIO: The American Dental
11 Association, about six weeks ago, put out another memo
12 saying they still felt amalgam is a good restoration
13 with no adverse benefits to the patient. I think that
14 anyone trying to justify removing a restoration that
15 was totally adequate just for the sake of saying the
16 amalgam was a poor adverse -- giving adverse reactions
17 to the patient, just to say by being -- by virtue of
18 being amalgam would not be allowed to be justified
19 along those lines.

20 MR. LESLEY: That's right. In some mechanism
21 to inhibit a tendency for a dentist to do that would be
22 an important thing to consider for (inaudible).

23 COL. CONCILIO: So you're recommending that a
24 statement would be made that a serviceable restoration
25 could not be simply for aesthetic reasons.

1 MR. LESLEY: Exactly.

2 COL. CONCILIO: Any other comments on this
3 topic? Along the lines of cost, again, talking still
4 about posterior composite restorations, what's likely
5 to impact the premium were the questions we had asked
6 on our website. The responses from industry were small
7 to moderate increase in premium cost. What we would
8 like to know is, what do you mean by small to moderate?
9 Are we talking a couple cents, are we talking 50 cents?

10 And again, would percentage of utilization
11 increase due to that should also force impact to
12 (inaudible). And just looking at this from my
13 financial point of view, what are your thoughts on the
14 placement of posterior composite of the benefit
15 package? Is small to moderate increase just a couple
16 of pennies? What do you mean by that increase from
17 your point of view?

18 MR. DAWN: I'm Lowell Dawn. The suggestion
19 that would be asked the industry (inaudible) actuary
20 and respond to you over the site with more specific
21 information. But generally from our standpoint, we're
22 talking about a two to three percent maximum increase.
23 A portion of that has to do with cost, a portion of it
24 has to do with utilization.

25 COL. CONCILIO: So both factors should be

1 taken into consideration? And again, what limitations
2 should be applied to the same type of composite
3 restorations. And the response we got from industry,
4 the same limitations and exclusions of other basic
5 restorative services, which I think I'm also hearing
6 from the audience as well. And then the frequency of
7 replacement ranges anywhere from two to five years as
8 far as what would be allowed in this part of the
9 package. And we would like to see if we could narrow
10 that two to five down to a certain number. That's a
11 fairly wide range of time as far as what you think
12 would be allowable if this restoration would need
13 replacement.

14 MR. DAWN: Lowell Dawn again. There is no
15 reason that a proper replacement restoration fee
16 (inaudible) everything 14 not to be lasting five years
17 unless there is traumatic injury or something along
18 those lines of course. It would be good for the
19 program if you established a five year replacement
20 limitation with appropriate safeguards for additional
21 diseases or traumatic injuries.

22 COL. CONCILIO: I assume that means
23 (inaudible) recurrent care doesn't (inaudible) just to
24 a poor replacement in the first place?

25 MR. DAWN: Correct.

1 COL. CONCILIO: Any other comments? Does a
2 five year time limit seem to be appropriate that this
3 should not be replaced other than the reason stated?

4 MR. (Unidentified): It is a likely point,
5 but I guess the question I pose is, if replacement
6 occurs within the five years, who assumes the liability
7 for that?

8 COL. CONCILIO: That's a question that we
9 look to industry to get some comments on.

10 MR. (Unidentified): I think because of that
11 question, I'm not sure I'm comfortable with the five
12 year recommendation.

13 COL. CONCILIO: What's your recommendation?

14 MR. (Unidentified): I think it's somewhat
15 shorter than that. There's no question that a well
16 done restoration should last five years. I wouldn't
17 argue that point. I think you're going to have enough
18 exceptions within the five years that you're going to
19 run into a situation on a pretty frequent basis.

20 As far as I know, certainly with regard to
21 Concordia, and I think for most other dental insurers,
22 two years now tends to be the time frame that most use
23 in the contracts. I could be wrong about that, but
24 that's my impression. That's what the industry
25 standard is today. I don't think it was too long ago

1 the industry standard was one in relationship with a
2 one limitation. So the two years I think is a
3 relatively new time frame. I don't think the industry
4 is ready for five years today, and I don't think the
5 industry will be ready for five years from basic
6 restorative procedure if the next half dozen years.
7 Not that we won't get there sometime, we're not there
8 today, and we won't be there certainly in the next
9 couple years.

10 COL. CONCILIO: Would you think that the
11 limitations for this be the same as amalgam as far as
12 number of years?

13 MR. (Unidentified): I would tend to use the
14 same policy, the same restrictions on composites as you
15 use on amalgams. Two years is the pretty much the
16 standard today.

17 COL. CONCILIO: Any other comments?

18 MR. DAWN: Lowell Dawn. Absolutely, I think
19 Tom is correct as far as what the standard is. What is
20 best for the patient and what might be the best for
21 this program could be a very different situation as far
22 as we're concerned.

23 COL. CONCILIO: Depending on that, would you
24 think the utilization would tend to maybe increase if
25 you had the lower limit?

1 MR. DAWN: Certainly it would increase. It
2 would have to.

3 COL. CONCILIO: And obviously we don't want
4 to have our quality decrease as a result of maybe
5 having a lower limitation either. We want to have the
6 best restoration choice there.

7 MR. DAWN: Sure.

8 COL. CONCILIO: Any other comments? Another
9 subject, orthodontics. Should we lower lifetime last
10 right now \$200 or \$300 in Government policy. We asked,
11 should we increase annual lifetime maximum for
12 orthodontics. And overall responses we got were no, we
13 should leave it alone. We asked what is the industry
14 trend. And it seemed like right now our plan is
15 probably at the higher end because our responses were
16 \$1,000 to \$1,500 lifetime maximum.

17 So just comments, what do you feel -- do you
18 feel with increased cost of orthodontics, and it seems
19 to be continually going up because our beneficiaries
20 keep going up, and we also (inaudible). Do you see,
21 over the next five-year period, that the industry
22 standards as far as the trend for lifetime maximum for
23 orthodontics change or increase slightly?

24 MR. RUBIN: You need to speak up a little
25 bit.

1 MR. LESLEY: Craig Lesley. The in the
2 commercial market as money is available, the lifetime
3 maximum for orthodontics has been inching up in \$100 or
4 \$200 or \$300 increments. In a recent union
5 negotiations war, a four year contract was agreed to.
6 There was a one-time increase of \$200 in the
7 orthodontic maximum from \$1,500 to \$1,700. And that
8 was to stay in place for a whole four-year period.

9 In orthodontic, you're beneficiaries are
10 correct. Orthodontic fees are for a whole practice
11 pattern, and as Lynn probably knows, are -- can run
12 \$3,000 to \$4,000. And essentially, you're virtually
13 assured that once an orthodontic case is started, that
14 the lifetime maximum will be used. And it's an
15 entirely different decision that you're making for
16 orthodontics with the lifetime maximum. How big a
17 check do you want to write versus an annual maximum to
18 be used by the family for it's dental diagnostic and
19 (inaudible). So an economic decision rather than
20 health benefit decision.

21 COL. CONCILIO: Since orthodontics as far as
22 (inaudible) obviously a lifetime maximum, I would say
23 majority of plans out there. If you do increase the
24 benefit, in your case, you indicated \$1,500 to \$1,700,
25 do you see utilization patterns change at all? Or

1 since the cost is so extensive -- more extensive than
2 that, they should stay the same anyway?

3 MR. LESLEY: The -- no, the utilization --
4 just the fact -- just coverage allows a family to make
5 orthodontics available. And there's -- so the better
6 the coverage, the happier they are. It just depends on
7 what the (inaudible). So it's a different kind -- if
8 the presence of orthodontics, yes -- orthodontic
9 coverage yes or no. Cost utilization, not necessarily
10 the lifetime benefit.

11 COL. CONCILIO: So a \$100 or so more or less
12 isn't going to change someone's perception (inaudible)?

13 MR. LESLEY: In my experience, no.

14 COL. CONCILIO: Any other comments on ortho
15 regarding utilization or changes in annual maximums as
16 far as your thoughts from industry on that? Do you
17 think \$1,500 is a good number that's the present
18 number? According to the responses we got back, it
19 seems like from what we hear, we're probably at the
20 upper end of what plans usually include at this point.
21 So I'm taking feedback I'm getting as saying that
22 probably the \$1,500 is a good number.

23 MR. HARBOLD: Tom Harbold. I think \$1,500 is
24 a good number. I think it certainly compares very
25 favorably. Not that there are some groups who do say

1 more than that or have a higher lifetime maximum, but I
2 think overwhelmingly most sit fairly well with the
3 \$1,500 or below that. So if the intent is to have a
4 program that compares well or favorably with industry,
5 I think you're already there with the \$1,500.

6 COL. CONCILIO: Along that line, I guess what
7 we should look at the overall program, the \$1,200
8 maximum per year, is that appropriate for most families
9 as well?

10 MR. HARBOLD: I tend to think so. Again, in
11 terms of what I think, it is pretty much the standard
12 or what existed in the industry. Certainty in our
13 experience, \$1,200 is probably a little more generous
14 than what most of our groups have today. \$1,000 is
15 probably a little more common at least with the
16 coverage that we write.

17 COL. CONCILIO: Again, along these lines,
18 should we modify age limitations? Our current plan
19 allows people to receive orthodontics up to age 23.
20 And we received some mixed responses, either no age
21 limitation for anything as far as orthodontics, or
22 maintain the status quo up to age 23. What are your
23 thoughts as far as that? Do you think our current
24 policy is good, or what do you think of the other -- I
25 guess as far as anyone can receive orthodontics as far

1 as age? I assume if anyone can receive it, it would
2 have a fairly costly implication as far as the overall
3 program. So that's why we would like your thoughts
4 along those lines. Any comments from industry as far
5 as age.

6 MR. DAWN: Lowell Dawn. Since Lynn is the
7 guinea pig this morning, obviously adult or very very
8 young adults, in their early 20s, I'm sure, receive
9 orthodontic treatment, we would recommend that there be
10 no age limitation on ortho.

11 COL. CONCILIO: And regarding the cost to the
12 overall program.

13 MR. DAWN: Leave it where it is.

14 COL. CONCILIO: But obviously if we did
15 increase the age to any age as opposed to a limit to
16 the age of 23, which it is now, there is implication
17 for cost as far as premiums?

18 MR. DAWN: There certainly would be an
19 overall cost increase. We think it should be very very
20 modest (inaudible).

21 MR. MATZKE: My take on this is -- Matzke.
22 If you want to eliminate the age limit, basically
23 you're making a decision to spend more money. We have
24 in orthodontic (inaudible) are much more popular. You
25 know, in society people want to look good. Cosmetic

1 dentistry is really taking off. They are trying to
2 increase their annual (inaudible). And to some extent,
3 it's really just a cost decision. Does the Government
4 want to really provide more money -- spend more money
5 to cover --

6 COL. CONCILIO: That's why we're asking the
7 question. I assume there's more and more adult
8 orthodontics being done, and we wanted to see whether
9 industry sees this taking off in the future as being an
10 additive to their programs -- commercial programs. I
11 don't see from the answers we got here, it didn't seem
12 like that is probably the normal at this point; is that
13 true?

14 MR. MATZKE: For us, that would be true. We
15 do offer it to our larger customers.

16 COL. CONCILIO: Is it a rider or part of the
17 program?

18 MR. MATZKE: As an alternative option, kind
19 of like a buy benefit. You buy additional coverage.

20 COL. CONCILIO: Do you find that that result
21 in adverse selection?

22 MR. MATZKE: Well, we certainly price for it.
23 We certainly are adding cost to it. Whether the
24 incident rate would go up, basically it's just going to
25 increase your cost. I can't really specifically

1 address the (inaudible).

2 COL. CONCILIO: So if I'm understanding you
3 correctly, you're saying you don't offer this option to
4 people in a general insurance policy? It's more of a
5 rider or something to that affect, and they pay the
6 additional amount for that?

7 MR. MATZKE: Yes. They specifically
8 (inaudible), and they want to. Arguably it's not an
9 insurable benefit. If an employer choses to basically
10 provide greater coverage, cover more of the cost
11 sharing (inaudible).

12 COL. CONCILIO: If that benefit is added, how
13 much additional cost would be -- we're talking from
14 your point of view, a tremendously large increase in
15 premium cost?

16 MR. MATZKE: I don't know off the top of my
17 head.

18 COL. CONCILIO: Any other comments as far as
19 this topic with age? So overall, I think I'm hearing
20 that even though we realize adult orthodontics is
21 increasingly being done, at this point, since it may
22 add at least some additional cost, that most likely
23 consensus is to stay at the same age limit. Is that
24 what I'm think I'm hearing from everyone? That's your
25 over all recommendation.

1 Do you find that this is a -- not necessarily
2 a normal (inaudible) going to increasing this to
3 (inaudible) adult orthodontics of any age without an
4 additional rider or that benefit being paid for at a
5 higher rate, I think is what I'm hearing from everyone,
6 to be included as just a routine policy for most
7 employers. It's not just point being done; is that
8 correct?

9 MR. DAWN: Lowell Dawn. Just to clarify, we
10 were recommending that you remove the age limitation.

11 COL. CONCILIO: From the other comments I've
12 been getting though, I think most people feel -- you
13 said that you didn't think it was a tremendous
14 increase, but it's going to obviously impact the
15 premium.

16 MR. DAWN: Certainly, it would.

17 COL. CONCILIO: Are you saying, you do this
18 -- what the other gentleman said -- as a rider or just
19 as a one premium benefit?

20 MR. DAWN: Just as part of the basic program
21 that you consider. I don't think you want to just
22 throw it out without any further consideration. But if
23 you make the determination, knowing that it will carry
24 a cost with it.

25 COL. CONCILIO: Again --

1 MR. HARBOLD: Tom Harbold. Again, within
2 reticence, I would be a little careful about that. I
3 think you really want to cross that out. In a program
4 that's really just a voluntary program (inaudible) but
5 clearly people make decisions about obtaining coverage
6 under this program, how long they stay, and based on
7 what they think there's a way to get out of it. And if
8 you simply open up the ortho benefit to anyone with no
9 age restrictions, I think you will have a fair degree
10 of adverse selection.

11 I'm not sure the impact on premium will only
12 be a modest one, whatever modest is. So I'd certainly
13 take a careful look at the cost implications and what
14 that will do to your total premium.

15 COL. CONCILIO: And I assume along those
16 lines, (inaudible) procedure, 12 months lock-in is not
17 going to cover those additional costs by itself.

18 MR. HARBOLD: That would be an (inaudible)
19 the degree premium of 12 months or two years. If your
20 treatment last over two years, which is fairly typical,
21 you're not going to recover and bring anything
22 approaching what you paid out of the orthodontic
23 benefit.

24 COL. CONCILIO: Another question along those
25 lines that we posted on our website was a two-tiered

1 benefit package of ortho coverage in tier 2, which I
2 guess is along the lines of a rider than with just
3 specified in. And the general comment was no. And I
4 assume that two-tiered benefit would additionally incur
5 some increased administrative cost as well to monetary.
6 And then should we eliminate ortho coverage from the
7 benefit package and offer it as an optional rider or
8 buy-up enhancement. (Inaudible) is what the other
9 gentleman had said. And that again, no. If we're
10 going to do that, that we would do it as part of the
11 overall premium package.

12 Next slide, please. Since our population
13 tends to move quite a bit and often in the course of
14 orthodontic treatment, which is a fairly lengthy
15 treatment anywhere. It's usually generally three to
16 four years on the average. We created a scenario here
17 saying enrollees actively undergoing comprehensive
18 ortho treatment, and the sponsor receives PCS orders to
19 relocate more than X miles, we assume that will be
20 probably greater than 50 miles from the original
21 servicing location. In other words, far enough that
22 they would have to change orthodontists during the
23 treatment plans. The enrollee moves to a new location
24 with sponsor and must find a new orthodontist incurring
25 additional expenses beyond the cost of the original

1 treatment plan.

2 What we have found from what our
3 beneficiaries said many times when they do have to move
4 during the course of orthodontic treatment, that the
5 new dentist doesn't necessarily use the same kind of
6 brackets or wires or just general orthodontic methods.
7 And so they have to go through maybe additional
8 treatment or a longer span of treatment. And the new
9 dentist incurs an additional cost, which right now they
10 don't get reimbursed.

11 So is it feasible to include an additional
12 ortho benefit -- dollar increase, which would be just a
13 few hundred dollars, we didn't specify what that would
14 be -- to ease financial burden to the sponsor. And we
15 got some mixed responses from the question, anywhere
16 from absolute no to absolute yes.

17 No, because it's difficult to administer. In
18 other words, if the patient would move, you would have
19 to make sure the patient would move to -- go ahead and
20 let the insurer know that they have moved, that there
21 is a new dentist involved, and that will add to
22 addition administrative costs.

23 The other responses we got were yes, we could
24 do that. Or that we could transfer a portion of the
25 remaining cost to that orthodontist. And whatever that

1 cost would be, whether it's 10 percent or something,
2 and reimburse along those lines as well.

3 So in this case, say I guess you call a PCS
4 ortho benefit of X amount, whatever it would be
5 possibly a few hundred dollars, would you recommend
6 that be done? What are your thoughts on this? And I
7 guess you could say that person is not getting the
8 \$1,500 or \$1,800 or \$1,900 benefit during the course of
9 orthodontic treatment. But this is mainly due to our
10 focus population, which does tend to relocate often
11 during the course of treat.

12 First of all, is it really -- does it really
13 incur a lot of additional administrative costs? And do
14 you think it's feasible or is it too costly to try to
15 do?

16 MR. HARBOLD: Tom Harbold. Certainly it's
17 feasible. I don't think, in terms of adding complexity
18 to the contract, that it would be that burdensome to
19 administer the benefit. Precedence has already been
20 established for certain other services that have
21 limitations associated with them where exceptions are
22 made to those limitation when the enrollee relocates
23 more than, I don't know if it's more than 40 to 50
24 miles offhand. To do something similar for the
25 orthodontic benefit, I don't think it has a lot of

1 complexity to administer it to the contract.

2 COL. CONCILIO: But it could, first of all,
3 affect potentially a few people. And some people might
4 view that as an uneven benefit just to say that I only
5 get \$1,500 because I'm not moving. If I move, I get a
6 greater benefit to my plan. Obviously they may have
7 some additional (inaudible) or may not. But that's a
8 perceived notion. Along those lines too, what would be
9 the additional burden on industry to do this? And
10 along those lines, what additional cost would be
11 incurred to do that from the point of premiums?

12 MR. HARBOLD: There would be -- you have to
13 do something in terms of administering the benefit. I
14 don't see it as particularly burdensome.

15 COL. CONCILIO: Would it be difficult to
16 track?

17 MR. HARBOLD: What?

18 COL. CONCILIO: Would it be difficult to
19 track that?

20 MR. HARBOLD: The way we handle the benefit
21 today as it relates to crowns and some of the other
22 services where we waive the time limitation is the
23 burden is on the individual and the dentist to inform
24 us either when they submit the claim, or what happens
25 probably just as often, after the claim is denied, we

1 get an inquiry. Once it's brought to our attention
2 that the individual has moved, it's usually handled as
3 an adjustment. It's not an ideal situation, but I
4 think most enrollees who are in that particular
5 situation don't feel too put upon by having to provide
6 the information to us.

7 I think this would be administered in a
8 similar fashion. It would be some burden on the
9 provider and/or the enrollee to bring the situation to
10 the contractor's attention.

11 COL. CONCILIO: So you don't think from that
12 point of view, it would incur that much in the way of
13 additional administrative cost.

14 MR. HARBOLD: It's not going to add
15 significant administrative costs to the program.

16 COL. CONCILIO: What as far as the premium
17 cost?

18 MR. HARBOLD: It will add some premium cost.
19 I don't think it will be real great, but I'm just
20 conjecturing quite frankly, and I'm not even an
21 actuary. I tend to think that, given this particular
22 population and the fact that they are fairly mobile,
23 and not of their own volition in most cases, that it
24 would be appropriate to allow some type of additional
25 benefit when they are required to relocate beyond a

1 certain distance. And when that necessitates that the
2 individual receiving ortho (inaudible) that they incur
3 added cost. I think it would be appropriate to allow
4 some type of additional benefit under those
5 circumstances.

6 COL. CONCILIO: Is there anything comparable
7 in terms --

8 MR. HARBOLD: I'm not aware of anything in
9 the commercial sector that would be comparable to that.
10 We tend to have pretty absolute rules in terms of
11 dollar limitations and frequency limitations. And
12 unless the group mandates some type of exception in
13 this specific instance, we tend to adhere pretty
14 closely to those rather inflexible rules in the
15 commercial environment.

16 COL. CONCILIO: Any other thoughts on that?

17 MR. GANUNI: Jerry Ganuni. We see the
18 commercial side of relocation as something of a
19 personal nature. So if you're going to get an enrollee
20 to get a benefit from moving to a location, it should
21 be outside the insurance policy. When we look at
22 orthodontia, it's never a set amount. Depending on the
23 severity of orthodontia, it could be as much as \$3,000.
24 It could go as high as \$4,500. There's always some
25 variable that (inaudible).

1 Just because somebody moves, why should they
2 should they be (inaudible). From an administrative
3 perspective from the commercial side, we don't do that
4 for any types of benefit. There's always exceptions
5 made based on the individual cases (inaudible) that
6 allows somebody to have an additional dollar just
7 because of relocation. It would add administrative
8 (inaudible) to the commercial side.

9 COL. CONCILIO: Now obviously our military
10 people who feel --

11 MR. GANUNI: In the commercial segment, you
12 do get (inaudible) --

13 COL. CONCILIO: Right. And that's what I
14 wanted to bring up because I think over the last 10 or
15 15 years of employee benefits, people tend to move for
16 reasons of jobs, or just we're tending to be a more
17 mobile society in any case. So that's why I wanted to
18 see if you saw that much of a difference between our
19 group of beneficiaries and (inaudible)?

20 MR. GANUNI: And that's how many times your
21 folks move versus the commercial side. But any time
22 relocation takes place, not just orthodontia, different
23 costs of rent and everything else, over and beyond the
24 insurance side, we don't try to make those types of
25 adjustments (inaudible).

1 Just from the commercial perspective, you
2 asked would it be more costly for us to administer the
3 benefit, and the answer is yes. There are more
4 administrative costs associated.

5 COL. CONCILIO: Especially on premiums?

6 MR. GANUNI: It's going to (inaudible). How
7 much, is hard to say.

8 COL. CONCILIO: Also the additional benefit
9 as well, whatever it could be --

10 MR. GANUNI: I think you open yourself up to
11 -- not discrimination, but certainly controversy from
12 one person saying, my benefit was \$1,700 and
13 (inaudible) was \$1,500.

14 COL. CONCILIO: Any other comments on that?

15 MS. HEAD: Mary, we're going to take a break
16 right now, which is probably a good time.

17 COL. CONCILIO: Thank you for your comments.

18 (Recess from 9:45 a.m. to 9:53 a.m.)

19 COL. CONCILIO: We're going to go onto the
20 next topic here in the benefit package, and that's the
21 topic of implants. And our question on the website
22 was, are commercial plans available that offer single
23 tooth implants and final restorations as covered
24 services. And our answer is yes -- consolidated answer
25 from everyone -- yes, there is either a routine

1 coverage or as an alternate benefit.

2 Again, the subsequent question, they are not
3 provided by report, and what limitations and exclusions
4 would you apply to include an annual or contract
5 maximum specific to implants was one suggestion, or a
6 couple of suggestions. Same limitations or exclusions
7 as other fixed prostheses, or include language to
8 specifically address any ancillary services such as
9 surgical services or something (inaudible) periodontal
10 services that might have to be done in conjunction with
11 the implants.

12 So taking all of these things into
13 consideration, what would you recommend as far as where
14 we should go with implants as part of our benefit
15 package? Comments please.

16 MR. DAWN: Lowell Dawn. There isn't any
17 reason that we can think of that implants should not be
18 covered under the same terms among the patient
19 exclusions as other fixed prosthetics are covered. The
20 science supports it. It's certainly is customary from
21 the standpoint of those patients that prefer implants
22 to other multi-tooth fixed prostheses. And there are a
23 lot of (inaudible) reasons to cover it. There is very
24 few (inaudible).

25 COL. CONCILIO: Now, the question is, as

1 implants are very expensive procedures, obviously
2 you're going to hit your annual maximum before you even
3 come to the implant itself, and without any additional
4 services that might be needed in conjunction with the
5 implants. How would you suggest that we handle that?

6 MR. DAWN: The maximum ought to remain the
7 maximum. The patient and doctor both need to make the
8 decisions about what to do and when. Probably -- most
9 probably, if we're talking a single tooth implant
10 situation, it would be compared to at least a three
11 tooth fixed ridge situation. The maximums are going to
12 be hit in approximately the same fashion. So there's
13 going to be a patient participation that has to be
14 determined, and that seems a very reasonable thing to
15 do.

16 COL. CONCILIO: As far as an annual maximum
17 specific to implants, do you see any need for that or
18 include it just within the set maximum already stated?

19 MR. DAWN: The ladder. Within the set
20 maximum already stated.

21 COL. CONCILIO: And as far as suggestions
22 about including language to address any kind of
23 ancillary services that are needed in conjunction with
24 the implants, do you have any suggestions along those
25 lines?

1 MR. DAWN: No. We suggest the covered
2 benefits as currently described should be sufficient,
3 and the patient and doctor together to work within
4 those confines to make decisions.

5 COL. CONCILIO: Would you suggest that these
6 implants be limited just to single tooth implants that
7 are done in conjunction with any other type of
8 treatment, such as dentures, that type of thing?

9 MR. DAWN: We would not recommend a single
10 tooth situation, no.

11 COL. CONCILIO: In any case, where an
12 indication is needed for the implants as needed?

13 MR. DAWN: Sure.

14 COL. CONCILIO: And you said you would
15 include that as routine coverage as opposed to an
16 alternate benefit?

17 MR. DAWN: That's correct.

18 COL. CONCILIO: Thank you. Any other
19 comments along those lines? You see that they will be
20 affecting premium rates significantly by adding the
21 implant. Any comments along those lines? And also
22 from the commercial point of view, are these service
23 offered up in commercial plans as buy-up enhancements?
24 Are they being offered routinely right now? I mean,
25 our perception is this is still down the road as

1 opposed to present day and time, but we want to know,
2 where does the commercial sector see this heading?

3 MR. LESLEY: They are starting to pop up just
4 once in a great while. Craig Lesley, and I represent
5 Delta Dental. They are starting to pop up once in a
6 while. They still are a very low frequency procedure,
7 although the science has caught up with any technique.
8 It has caught up so that when they are done, the
9 success rate today is much better than when they were
10 first introduced in the field of dentistry.

11 COL. CONCILIO: And your commercial plans
12 that do offer them, how are they generally offered?

13 MR. LESLEY: They are not broken out -- they
14 are handled in the way the previous speaker, Dr. Dawn,
15 described as a part of the plan.

16 COL. CONCILIO: As a covered benefit, not as
17 an alternate benefit?

18 MR. LESLEY: Yes.

19 MR. GANUNI: Jerry Ganuni. On the commercial
20 side from the fully insureds perspective where the
21 customer is actually paying for coverage, we're not
22 seeing those type of benefits yet in our plans. We're
23 seeing this in the large employer on an ESO basis where
24 we're doing the administration. Many of the large
25 employers are heading down that path.

1 I think the science does support the fact
2 that implants are certainly the waive to the future.
3 It's less intrusive to the individual, depending on the
4 situation. They are very very costly. So as a result,
5 we will get the maximums of your benefit much quicker.
6 Is it going to have an impact on the premiums, the
7 answer is absolutely, yes.

8 COL. CONCILIO: Along what lines?

9 MR. GANUNI: Just because having one done
10 from a standpoint of cosmetically, it's much easier on
11 the individual. It looks better. I think you are
12 going to find utilization trends will increase if you
13 start to cover them, and they're going to get to the
14 point where you're going to be eating those maximums
15 more often than you have in the past. That ultimately
16 is going to drive up the cost.

17 COL. CONCILIO: Other comments on implants?
18 Do you see over the next five years that because they
19 are being done more and more frequently in dental
20 offices, that there will be pressure on employers to
21 include this in dental plans, or at this point is it
22 still such a costly procedure it does tend to be
23 somewhat cost prohibitive to do that? Even not
24 necessarily right now, but over the period of time.

25 MR. LESLEY: Craig Lesley again. You asked

1 two questions. One, is there pressure on the employers
2 to provide that benefit, and the answer is yes. And
3 the second question in particular, is this because of
4 the cost, and the answer is yes.

5 COL. CONCILIO: That's what we suspected.
6 Next slide, please. As far as cost shares, currently
7 we have certain procedures that our younger enlisted
8 service members, grades E-1 to E-4 get certainly cost
9 shares at a lower cost share rate. And if we limit all
10 cost shares instead of just certain procedures to 20
11 percent to grades listed E-1 to E-4, what impact will
12 that have on our premium rates. And I think the
13 consensus did seem to say this will cause a significant
14 increase in premiums for this population.

15 I assume -- and this is subsequent from my
16 point of view, is that, first of all, this is a
17 population where you have a great number of people.
18 And also I assume that since the cost shares would be
19 at a lower rate, that you tend to think that they'll be
20 a higher utilization pattern. Are my assumptions
21 correct on that point or the answer is you think that
22 there could be a significant increase on the premiums?

23 MR. HARBOLD: Tom Harbold, United Concordia.
24 I would agree with the comments. I'm not sure that the
25 increase would be quite as significant as you might

1 anticipate from that. While there's a fairly sizable
2 population that falls within those pay rates in terms
3 of their actual enrollment in the program, their
4 enrollment levels are relatively low or certainly
5 significantly lower than individuals at higher pay
6 rates.

7 So while the impact on premium, there will
8 obviously be some because they don't tend to enroll in
9 as great of numbers as higher paid grade levels. The
10 impact may not be quite as significant as you might
11 think.

12 COL. CONCILIO: Any other comment as far as
13 enlisted premium? And our second question is how would
14 this change impact recruitment of dentists into the
15 network? And overall, I think that really wouldn't
16 impact network at all. It really had no changes as far
17 as that concern.

18 Next slide, please. Provider networks. As
19 Lynn Head told you previously, we only have provider
20 networks in CONUS, continental United States. And
21 we're looking at some questions pertaining to those
22 networks. First of all, are commercial plans available
23 that offer exclusive provider network in large urban
24 areas with high concentrations of beneficiaries and
25 dentists. And the consensus opinion seems to be, yes,

1 there are such things, but they tend to be for the
2 dental HMO type option rather than a service type
3 option.

4 And how would you recruit dentists to
5 participate in this network, and what incentives. And
6 we got some mixed responses along those lines. I'm not
7 sure exactly what the first one (inaudible), but it
8 says, waives and documentation requirements. I assume
9 that that doesn't have anything to do with
10 credentialing and privileging requirements. But I'm
11 not sure exactly what that comment meant, so I'll have
12 to move on.

13 Offer a five percent higher allowance and
14 other perks, which seemed reasonable, or offer no
15 incentives at all. As far as potentially offering
16 certainly types of networks and greater concentration
17 areas of beneficiaries and dentists, what would do you
18 think we could do to enhance network participation in
19 that area? Any comments on networks?

20 MR. HARBOLD: Tom Harbold, United Concordia.
21 If I understand the question, I'm not sure EPN enhances
22 the network.

23 COL. CONCILIO: That's what we wanted to see
24 if we were going along the right lines in that respect.

25 MR. HARBOLD: The limited experience that we

1 try to determine the EPN, I think there tends to be
2 perceived or handled as a much more limited network
3 situation in terms of the number of providers that
4 you're seeking to have in that type of an arrangement.
5 So if you're talking about an enhanced network
6 arrangement if that suggest greater access, I think you
7 would normally end up with the opposite effect. You
8 have a much smaller network, with much more restricted
9 access. I think that's one of the reasons that they
10 tend to be used as sort of an alternative to a DHMO
11 probably in some places where you have difficulty
12 recruiting dentists to be part of the HMO.

13 COL. CONCILIO: As far as access to dentists
14 in large metropolitan areas where there are a
15 significant number of dentists, and we wanted to have
16 our beneficiaries have ease of access to the dentist in
17 that area, what types of incentives could be
18 potentially given to have a dentist join the network
19 and potentially also limit what patients have to do for
20 pre-authorization to those dentists as well to enhance
21 the beneficiary satisfaction, for instance.

22 MR. HARBOLD: Again, if I understand the
23 question, you're talking about enhancing access in
24 large metropolitan areas, I don't think you have a
25 problem there.

1 COL. CONCILIO: What about other areas, what
2 can you do to encourage good provider networks for our
3 patients?

4 MR. HARBOLD: That's a good question. I
5 think some of us struggle with that questions on a
6 pretty regular basis. Because frankly, in various
7 areas it doesn't matter what you offer, you're not
8 going to get a significantly large network. So if you
9 rule out force, I don't think you're left with much in
10 terms of recruiting dentists into the network in some
11 areas.

12 COL. CONCILIO: You think that five percent
13 incentive is enough to encourage people to join
14 networks?

15 MR. HARBOLD: No.

16 COL. CONCILIO: Money alone won't do it.

17 MR. HARBOLD: Money alone will not do it.
18 Maybe a new generation, if we can wait 20 or 30 years,
19 might achieve some change, but I don't think you're
20 looking 20 years down the road.

21 MR. MATZKE: Mark Matzke. I just thought I'd
22 throw a comment out there which kind of relates to my
23 first questions of the day, which somewhat amazes me.
24 Most of us in the commercial dental industry have spent
25 years building network -- PPO networks, and have gone

1 out and tried to contract at the best rate possible to
2 pass those lower fees along to the members and
3 purchasers, products, employers, and so on. It seems
4 like this program doesn't allow you to take advantage
5 of those deals that we have created, which clearly
6 would provide a substantial benefit to the members of
7 the TRICARE Dental Program.

8 COL. CONCILIO: You're talking -- when you
9 say TRICARE Dental, in what way --

10 MR. MATZKE: For instance, typically the 50
11 percentile is closer to mean charge?

12 COL. CONCILIO: That's correct.

13 MR. MATZKE: And more often than not, when
14 folks build networks there are a couple different
15 strategies. Some build very large networks where you
16 might have 80,000-90,000 dentists nationwide with
17 percentages of 120,000-140,000, depending on the list
18 you have. In order to get that big, generally they
19 contract at current (inaudible).

20 There are other PPO networks that folks have
21 been able to build that can range from anywhere -- a
22 good size one to 150 to low 60's where the discounts
23 are actually substantially significantly lower than
24 mean charge. It results in some significant savings.
25 Which, you know, if somebody happens to go in the

1 networks, there is a clear advantage for somebody who
2 purchases this plan if I can go to any network
3 provider, and instead of being charged \$30, I'm now
4 being charged \$20 for a particular procedure.

5 COL. CONCILIO: But from a provider point of
6 view, which is difficulty recruiting those dentists
7 because you are paying a significantly lower rate than
8 (inaudible).

9 MR. MATZKE: Yes that is definitely true.
10 What I'm saying is most carriers have already recruited
11 them.

12 COL. CONCILIO: Is it because they are
13 already in other plans in that area that -- and this is
14 just a similar type program? Or you're using --
15 obviously you're talking about using existing networks
16 then?

17 MR. MATZKE: Yes. (Inaudible) some
18 contractual obligations to one another required to keep
19 it in (inaudible). And for the most part, you're
20 offering a very similar commercial plan (inaudible).

21 COL. CONCILIO: What is your suggestion we
22 do?

23 MR. MATZKE: Apply the deals.

24 COL. CONCILIO: Deals in what way? You
25 didn't like the way we initially said as far as what

1 our network standards are now, what would you word
2 differently in there.

3 MR. MATZKE: Quite honestly, I'm not sure I
4 understand how dentists get contracted today for this
5 particular contract. It sounds like the people who are
6 building networks are forced to actually build a
7 network based on fees that are higher than are
8 typically what the average charge is. If I was a
9 dentist, I would definitely want to be in there because
10 it's much better than being in the other (inaudible).

11 COL. CONCILIO: I see what you mean. Thank
12 you.

13 MR. PRYOR: Ray Pryor. I would just add one
14 comment to it. I think as one of the objectives going
15 in to this industry forum, they said what we were
16 looking for was what's happening in industry. We said
17 we're going to be less prescriptive and more result
18 oriented. So I guess what I would suggest to the panel
19 is, if we're looking for results, let's focus on those,
20 and tell us to get the network necessary to provide the
21 service. And I'm not sure it's always dollars.

22 Large metropolitan areas are probably not the
23 coin of realm for you. We enjoy providing service to
24 several of your locations now. Most of them are not
25 frankly in large metropolitan areas. So there's a lot

1 of network development kind of things that need to
2 occur. And I think we've been pretty successful in
3 building some. So I would ask you have to some
4 latitude here as not being so prescriptive but more
5 results oriented.

6 COL. CONCILIO: And along the other lines of
7 networks, do you feel that doing it that you can still
8 meet the access standards that we have prescribed?

9 MR. PRYOR: I believe we can. And though I
10 have more experience on the med surg side, we have some
11 very small areas when we first started in Mississippi
12 and Louisiana, et cetera, et cetera, they couldn't
13 spell managed care. But we have been able to maintain
14 an adequate network in the dental arena.

15 COL. CONCILIO: Along those lines, there's
16 certain areas where in terms of local providers can be
17 a bit recalcitrant to network formation.

18 MR. PRYOR: We have experienced those as
19 well. I think one actually said to me, "We threw the
20 last three managed care folks out of here, what makes
21 you think you're going to get to stay?" We're still
22 there, and we want to contract a second time.

23 COL. CONCILIO: Thanks. Any other?

24 MR. HARBOLD: Tom Harbold, United Concordia.
25 Just one or two comments (inaudible) previous speaker's

1 comments. I don't think that the program today
2 precludes the contractor from making special deals.
3 It's that sort of a minimum requirement today. The
4 wisdom of that you can argue one way or the other. But
5 the requirement that does exist today is simply a
6 minimum requirement. It doesn't preclude, as least as
7 I read the contract, the contractor departing from that
8 as long as they don't go lower in specific instances,
9 either area based or with respect to specific providers
10 if that's what it takes to establish a network in a
11 given area.

12 So I think in the contract that exists today
13 there is a fair amount of flexibility in terms of
14 building a network. In terms of sort of a draft
15 statement award or whatever was put out on the website,
16 I didn't see anything there that precluded a contractor
17 from making deals if that's what they felt they needed
18 in terms of establishing a network.

19 In terms of how you get dentists in the
20 network, while money certainly is a driver, but
21 frankly, I don't think it's the primary driver in a lot
22 of instances. There's no question if you have a
23 sizable patient population in a given area and you tend
24 to have that in this program around most of your bases,
25 you got a fair amount of leverage in terms of getting

1 providers to enroll in the program.

2 There are other things that you can use to
3 make a network attractive. The item up there that you
4 were a little confused about, United Concordia, for
5 example, a commercial business has something called an
6 honors program. And basically under that program, we
7 allow providers to not have to submit x-rays for
8 procedures that they would normally be required to
9 submit x-rays with their claims for. They have to go
10 through a qualification process, so to speak, to be
11 given that status or to be admitted to that status.
12 But those who do meet those qualifications find it to
13 be a value to not have to submit x-rays routinely for
14 certain procedures.

15 There are other things that you can do that
16 will make a network attractive to at least some in some
17 areas. There are certainly areas that I think
18 indicated earlier, I don't think it's a matter of much
19 of what you offer, you're going to have a tough time in
20 getting a dentist to enroll in a network.

21 COL. CONCILIO: I think everyone knows or has
22 seen evidence in the news lately that there could
23 potentially be movements of troops back from overseas
24 back to some CONUS locations at some point in the
25 future as we relocate some of our service members

1 overseas back here or even other locations overseas
2 obviously as well, but mainly back to the states. How
3 do you think that that -- the networks can accommodate
4 large groups of people and their family members as well
5 coming back to obviously larger -- some of our larger
6 CONUS locations but not necessarily? So how do your
7 networks adapt to those changing schemes along the
8 line?

9 MR. HARBOLD: I'm not sure if I can answer
10 that. I think they just sort of make that if the
11 patients are there. And again, I think it depends a
12 little bit on where there is and how many dentist do
13 you have in the network, how busy they are, et cetera.
14 Again metropolitan areas, there tends to be a
15 sufficiently large number of dentist, so it's probably
16 more of a buyers market than a sellers market there.

17 In other areas, our experience probably
18 focuses more on rural areas where there tends to be a
19 limited numbers of providers available. And they also
20 tend to be somewhat more independent minded. If you
21 put huge numbers of people in there that weren't there
22 previously, it could create problems -- some access
23 problems. But without knowing specific places and
24 looking at each of those in terms of what's available,
25 given the contractor already has in the way of a

1 network there, it's (inaudible) the answers to that.

2 COL. CONCILIO: But you think since most of
3 the these movements take place over a period of time,
4 usually two or three years at the minimum, that given
5 advanced notice, most networks can adapt the changing
6 numbers of family members to another location if
7 needed?

8 MR. HARBOLD: I'm not sure it's a matter of
9 giving sufficient advanced notice. I think it's more a
10 matter of the network in most places will, in one way
11 or another, accommodate the additional family members
12 that are there. Where you have a problem, then you
13 you're going to be have a problem a year from now if
14 you bring in large numbers of people. If you don't
15 have a problem today, you probably won't have a problem
16 six months from now if you bring in a sizable number of
17 additional people.

18 COL. CONCILIO: Thank you. Other comments on
19 network?

20 MR. MAYS: I want to ask a follow up on the
21 networks. One the comment was that we needed to list a
22 standard and allow you tell us how you are going to do
23 that, and I think (inaudible) we want to do that as
24 much as possible. Right now the current contract in
25 what you have to have states in section C, states an

1 access standard of 35 miles and 21 days for an
2 appointment. And I would like to know from your
3 perspective, is that a reasonable standard in industry?
4 Do we need to change that standard to address rural,
5 urban, suburban situations? What's your experience.

6 MR. DAWN: Lowell Dawn. To answer the second
7 -- this last group of questions first, and then get
8 back to the earlier one. Those standards are very
9 reasonable. There isn't any need in our estimation to
10 have a differential between urban, suburban, and rural
11 as long as you understand, as Tom has mentioned, there
12 are some places in this country where there just are
13 not dentists, and you can't apply a standard where
14 there are no dentists existing.

15 As long as you accept that, those are few and
16 far between. You can count them on one hand probably.
17 Those are few and far between. But accepting that, the
18 standards that you have 35 miles, 21 days is very
19 reasonable and appropriate.

20 Back to the earlier discussion, and here
21 again I agree with what Tom was saying, although I
22 would urge you to think of this not just as a network,
23 but also go to the more basic level of what the dental
24 profession is going to do in those environments and
25 those situations, the network being a subset of that.

1 And all of the economists will tell you that if the
2 patient load is there, either the chairs are going to
3 increase or the chair hours will increase or the number
4 of providers will increase to accommodate the
5 population. And it's then our obligation as your
6 contractors to go to that new provider community, if
7 you will, and recruit appropriately for the network to
8 the network standards that you established.

9 But those changes of behavior by the provider
10 are what is going to meet your need. It has nothing to
11 do whatsoever with the ratio of patients or providers,
12 for example. The numbers will take care of themselves
13 and address the need in that community.

14 COL. CONCILIO: And along the lines what I
15 mentioned before, as far as influx of additional
16 patients due to outside forces, how do you propose
17 changing or adding to the network to adequately adjust
18 to the new population.

19 MR. DAWN: Well, going back to the basic
20 premise that the provider community will respond to
21 that itself, if that response is not adequate, if it's
22 not happening soon enough, or if there's a special DOD
23 related need, you should expect your contractor to be
24 out there recruiting new dentists into that area with
25 whatever incentive the contractors need to offer.

1 Having said all of this with regard to networks,
2 closing comment, you very likely do want to have a
3 different standard as far as OCONUS is concerned.

4 COL. CONCILIO: And we will get to that.

5 MR. HARBOLD: Tom Harbold, United Concordia.
6 To get back to the earlier questions, I think the
7 current standard for 21 day, 35 mile rule is a
8 reasonable way of measuring or enforcing some type of
9 access standard. It's certainly a little somewhat
10 arbitrary. It doesn't fit some situations very well.
11 The problem is, I can't think of anything that would be
12 better. We've wrestled with that issue to see if we
13 could perhaps offer some ideas. And frankly, no matter
14 what type of standard you establish, it going to have
15 to be somewhat arbitrary. And frankly, I can't come up
16 with anything that I think is a better way of some type
17 of minimum requirement. And I don't think it's that
18 burdensome for the most part. There are some places
19 that it creates a significant challenge, but that's
20 part of the job of being a contractor, I think.

21 MR. MATZKE: Mark Matzke again. I don't have
22 anything to add on network access. But I wanted to
23 make sure that I got my point across before. When I
24 look at how the networks are built and what the
25 allowances are that are paid to the participating

1 dentist, I just want to make it clear that everybody
2 understands that it is rare where we would actually
3 contract with a dentist sufficiently higher than the 50
4 percentile. So what that means is more often than not,
5 if we were to overlay our network, we would actually
6 provide a better benefit. Does that make sense?

7 COL. CONCILIO: Yes. That makes sense.

8 LT. COL. EDWARDS: Can I ask a follow up
9 question? My understanding is that essentially what we
10 have in our draft statement at work is a 50 percentile
11 floor. You are saying a lower floor would actually
12 create a better situation for us?

13 MR. MATZKE: Yeah. I'm suggesting
14 eliminating the floor completely. To some extent if
15 you're creating a 50 percentile, that means that 50
16 percent the dentist charge less than that, and 50
17 percent charge more. In order for a carrier to get
18 sufficient access, chances are that there are is a
19 chance you actually entail more on average than they
20 would if they had no contract at all because they have
21 to go out and contract with somebody to meet the access
22 standard. And generally you do set a floor of 50
23 percent, which means that I the contractors tell me
24 greater than or equal to roughly the average charge.
25 So my network, you know, theoretically is going to have

1 to charge higher than the 50th percentile.

2 COL. CONCILIO: You don't think that would
3 adversely affect network development?

4 MR. MATZKE: I don't think so today because I
5 think carriers have been successful building networks
6 without any restrictions. The larger the network,
7 basically the lower the discount. It's just the way it
8 goes. They universally correlate. It's hard to build
9 a big network when (inaudible) deep discounts.

10 COL. CONCILIO: And how many -- do you think
11 that would lead to many regional variations because of
12 that? Because I would assume that you would have go to
13 a population that would accept that rate or whatever
14 rate you were offering?

15 MR. MATZKE: I mean, essentially people would
16 be asked to meet the access standards regardless of
17 what they have to actually put out there as an
18 allowance. So to the extent they got something in
19 place and they can meet those access standards, great.
20 If not, I mean, there's certainly areas in the country
21 that have traditionally been very (inaudible) to
22 contracting. And chances are, if someone had to meet
23 an access standard there, you might end up having to
24 strike deals that aren't necessarily in the best
25 interest financially.

1 LT. COL. EDWARDS: Would other industry
2 representatives agree with eliminations of the floor?

3 MR. LESLEY: Only if you're prepared to
4 eliminate the access standards. I'm sorry, Craig
5 Lesley, Delta Dental. This stage of the industry and
6 our foreseeable future and access standards across the
7 broad geographical spread of your population, I would
8 think that the access standard and the eliminating the
9 minimum payment mechanism would be mutually exclusive.
10 And special deals would have to be cut in order to meet
11 those access standards would require paying dentists
12 above the medium, and we'd be back to why do we go in
13 that circle. So no, I think that you would be
14 fundamentally changing the goals, objectives, and the
15 missions of this program by making that change in my
16 opinion.

17 COL. CONCILIO: How does our standard compare
18 to industry standard as it currently stands out there?

19 MR. LESLEY: If you -- I'm going to respond
20 by trying to recall from memory the latest National
21 Association of Dental Plan's market survey, NADP market
22 survey. And even with the managed care options that
23 are available today in the general marketplace, over 50
24 percent of the people still have a plan that pays ROC's
25 with ROC's being defined as something more (inaudible).

1 So over 50 percent of the people today are
2 still receiving care -- if not well above 50 percent --
3 are still receiving care in an environment that is the
4 environment that your beneficiaries are receiving care
5 in terms of how much managed care is being applied to
6 the program.

7 COL. CONCILIO: From industries perspective,
8 do most commercial programs define an access standard
9 similar to our or some type of access standard?

10 MR. LESLEY: Yes. And the term is access
11 points because -- and that the industry standard
12 there's a tool out there called geo-access, which I'm
13 sure everybody is familiar with. And they -- the best
14 measurement within that tool is access points. How
15 many dentist can you find at how many locations. And
16 so a specialist may practice Monday or Tuesday in
17 Aurora, and Wednesday and Thursday in Denver. Well,
18 that's two access points because that dentist is
19 available in two places over the course of a week.

20 And there are a lot of areas made and
21 analysis because people find an access point in a
22 provider. But once you get that cleared out, and
23 describe what you want in the geo-access report, then
24 we will be able to compare apples to apples in
25 networks. And what we do on the commercial side, and

1 that's why I'm here today because it's where I spend
2 the majority of my time, is we mostly are completed on
3 broad access for people in major national accounts.
4 Fortune 500 is the standard comment to make about that.
5 But they have people that are in virtually every zip
6 code in the United States, and therefore, their
7 requirements for access standards are different than a
8 company that might have two or three locations in very
9 prescribed geographic locations.

10 So most of the care today, most of the plans
11 today are looking for a balance between cost and access
12 in choosing convenience, low hassle, and broad access
13 for the people.

14 COL. CONCILIO: But along with the access
15 standards, not just a question of location, if you want
16 to have access within 21 days or whatever the defined
17 time period is, how do you measure that? You want to
18 make sure that people are actually accepting patients,
19 not that they office there.

20 MR. LESLEY: That's network management. You
21 have to ask the question about how the bidder expects
22 to meet that very serious part of the requirement.

23 COL. CONCILIO: And how do you generally do
24 that? How do you know that they have open appointments
25 available?

1 MR. LESLEY: Through our -- the fact --

2 COL. CONCILIO: How do you think industry in
3 general, not necessarily you --

4 MR. LESLEY: Industry in general doesn't keep
5 all that close a track to it. That's an additional
6 requirement. But there is -- you have ways within your
7 provider record to identify those dentists that are
8 accepting new patients into their practice and those
9 who aren't. And you do the very best you can to keep
10 that up to date.

11 COL. CONCILIO: So it's actually surveying
12 your participating providers on a regular basis?

13 MR. LESLEY: There's probably as many
14 different ways to do that as there are organization
15 representatives in this room.

16 MR. MATZKE: Mark Matzke again. I would
17 agree with comments on network access in that
18 commercially it's fairly consistent. I would say that
19 I disagree that they need to be tied together, that
20 being access and that being setting some sort of a
21 threshold when it comes to developing contract work and
22 allowances with a particular dentist.

23 To some extent, it handicaps us because
24 ultimately we're going to bid on this contract, and
25 it's -- we're going to take on the full risk of the

1 contract. By not allowing us to actually take
2 advantage of some of the contracts we have in place,
3 it's forcing us to put forth the (inaudible) and
4 ultimately, it's going to cost the Government more
5 money.

6 COL. CONCILIO: How do you define your access
7 as far as -- not just location of providers, but again,
8 what I said as far as making sure that they have
9 appointments available in a certain standard of time.

10 MR. MATZKE: Similar to what the gentleman
11 stated before. We use geo-access, and the access
12 standard really varies substantially. More often than
13 not in commercial markets (inaudible) puts forth in
14 RFP. They'll define access standards that can vary
15 substantially, but could be one minute and 10 miles.
16 It could be 30 miles, 25 miles, it really varies.

17 MR. HARBOLD: Tom Harbold, United Concordia.
18 I spent very little -- actually no time on the
19 commercial side. So I'm a little uncomfortable
20 commenting on that. But it's my sense that access is
21 measured and viewed somewhat differently in the
22 commercial environment that it has been historically
23 under this program. From what I understand on the
24 commercial side, there's a tendency to look at whether
25 you have within or (inaudible) within X miles. It may

1 be 10 miles, it may be 25 miles, or it could even be 35
2 miles. But I tend to think 10 or 25 miles are the
3 reference points used more frequently.

4 I don't think the ability to obtain an
5 appointment within a certain period of time is
6 something that gets much attention from the commercial
7 side. This program has the expectation that at least
8 95 percent of the population, at least historically
9 that's this particular program when it was put out for
10 bids, that was the requirement that was expected. I
11 don't think that the commercial side has a similar
12 expectation in terms of 95 percent of enrollees would
13 have whatever access level that is deemed necessary or
14 appropriate to those contracts.

15 I think there's a further question, and that
16 is a difference or perception of what's adequate versus
17 what level of access you really want for this program.
18 And there is a world of difference between the two.
19 Historically I think this program has encouraged broad
20 access to a large number of providers, not simply
21 meeting some minimum requirement. And there are
22 differences in how you reimburse out of network
23 services depending on whether or not you meet the
24 access requirement. And again, I think that's somewhat
25 unique to this program.

1 I think in the commercial environment there
2 are a fair number of groups that have an out of network
3 allowance, in some cases significantly more generous
4 than what's paid in network. But it doesn't change
5 from one area to another based on whether there's the
6 availability of a network dentist or not. So I think
7 there are some pretty significant differences in terms
8 of how this program historically has approached the
9 question of access to a network dentist versus how I
10 think it tends to be viewed and measured on the
11 commercial side.

12 COL. CONCILIO: Any other comments from your
13 perspective? Next slide please. Along with provider
14 networks, this slide was not on the website. But some
15 thoughts that I had, and I wanted some comments back
16 from industry on this area of electronic claims.
17 Should we encourage network providers to submit
18 electronic claims and accept reimbursement by
19 electronic funds transfer? And I'd like to know your
20 thoughts.

21 It seems from what I read and heard and
22 discussed with my colleagues, electronic claims is
23 lagging a bit in the dental arena compared even to the
24 medical side. And I wanted to know your thoughts as
25 far as where the industry is going in this area?

1 MR. HARBOLD: Tom Harbold with United
2 Concordia. I have a fair amount of experience with
3 electronic claims (inaudible). I've been beating my
4 head on that wall for a number of years also.
5 Electronic funds transfer, I don't think it's a major
6 issue with most dentists. Certainly that's not the
7 feedback we're getting from surveys that we do on a
8 pretty regular basis of our provider population.

9 I'm not sure what it does take to get
10 dentists to submit claims electronically, because we've
11 expended a fair number of efforts and done sizable
12 number of things to encourage that. And we've had
13 growth over the years, but certainly not at the rate we
14 would like. For the TRICARE program today, we do get
15 about 30 percent of claims electronically. And that
16 compares pretty well with what we experience on the
17 commercial side.

18 That's probably not as high as some carriers
19 experience, but there's also the factors that sometimes
20 enter into that. We have what we consider our pass
21 through rate, which I think is much higher than what
22 tends to be experienced by many other carriers. I
23 don't know what it takes frankly to get some dentists
24 to submit claims electronically because we've gone over
25 it on a pretty regular basis and tell them or ask them,

1 what would it take and whatever they tell us we're
2 pretty amenable to as a rule, and still we have a fair
3 amount of difficulty getting a sizable number of
4 offices to use electronic claims submission.

5 COL. CONCILIO: Do you think it's mainly
6 because the dental industry as a whole has not
7 developed a common form, or that dentist offices just
8 tend to be resistant to change and don't want to bother
9 putting in new software changes or other things? Do
10 you think dentists are amenable to incentives to
11 increase the use of this in their offices.

12 MR. HARBOLD: I think it's a combination of
13 most of those things. I think there -- one or two
14 other things. First, I think there are a sizable
15 number of dentists that are just kind of phobic about
16 the use of computers and some of the newer technology.
17 It's still -- they were in a commercial environment and
18 working for an employer, they still want to get their
19 check each week and not have the funds automatically
20 deposited in their account. That is sort of my
21 perception.

22 I do think that there are a percentage of
23 providers that they are successful in getting some
24 offices to go electronically. What keeps some of them
25 today, I think there's a phobia about making the

1 change. This program and a lot of commercial programs
2 have time frames in which claims are expected to be
3 processed. When you're processing 90 percent of claims
4 in 14 days or less, to submit them electronically
5 doesn't save them a lot of time in terms of getting the
6 payment back. And usually people, when they make the
7 switch, it's a one time hit. And then after that, they
8 just get that weekly check or whatever.

9 So one of the things we hear from a lot of
10 offices is they're very happy today submitting the
11 claims on paper because they get good turn around in
12 terms of getting payment. Cost is a factor with some
13 of those offices. Most offices, if they submit through
14 a clearing house, which is pretty common today, the
15 going fee or a clearing house is usually around 45
16 cents, give or take a nickel, to the office for each
17 claim they submit. So something we hear from a fair
18 number of dentists is, I could put 10 or 15 claims in
19 an envelop and it costs us 37 cents or a buck whatever
20 to send them in. If I send the same claims in
21 electronically, I'm going to pay 45 cents a claim or
22 \$4.50.

23 And you can suggest to them that their annual
24 administrative costs by doing it paper, but that isn't
25 as easy to measure and you can't convince them most of

1 the time. So I think it's a combination of factors,
2 and most of us I think sort of plug away picking up an
3 office here and office there, and over time the
4 percentage gradually creeps up. And I think it will
5 continue to do so, but at a glacial pace.

6 COL. CONCILIO: But you don't see the
7 industry furnishing this overnight?

8 MR. HARBOLD: We've been trying that
9 overnight for about ten years, and we're still waiting
10 for the morning.

11 MR. LESLEY: Craig Leslie again, and I agree
12 with my colleague from across the aisle. Dentists,
13 with all full respect to any dentist who may be in the
14 room, you can't get into dental school unless you can
15 prove without a doubt that you are independent. And
16 once you graduate from dental school, it is your goal
17 for the vast majority of dentists to practice
18 independently. And they make independent decisions.
19 They know more about the cost that drives those
20 independent offices than many of us might think they
21 do, which allows them to very carefully analyze
22 requests for participating in networks.

23 But when it comes to electronic claims, I
24 agree with Tom that they do know that it can cost more
25 to send electronic claims than it does traditional

1 paper claims. So there are industry solutions, there
2 are independent industry (inaudible) solutions. And I
3 would support the word encourage. In other words, that
4 TRICARE become part of the purchasing community that
5 encourages it's dentist to do this. And secondly, I
6 would suggest that you could ask in the RFP what
7 individual bidders projects, plans, and goals are in
8 this area because it will tell you with how engaged we
9 are and what level (inaudible).

10 COL. CONCILIO: So it seems like industry is
11 trending that way, but not in the immediate future.

12 MR. LESLEY: Industry is working hard to move
13 the percentage of electronic claims up. But there are
14 a lot of hurdles including transaction charges and
15 including independent dentist reluctance to change.

16 LT. COL. EDWARDS: And I guess what I learned
17 from the discussion is that increased postal rates will
18 draw dentists to increase claims electronically.

19 MR. LESLEY: We rather that be on the record
20 coming from you as opposed to us.

21 COL. CONCILIO: Continue with the topic of
22 provider networks. Would requiring a TDP only network,
23 as you might say, negatively impact the program? And
24 how would this impact the network size? And I think
25 the consensus was generally it would reduce network

1 size and limit access. And a corollary to that
2 question we have, should providers be given the ability
3 to opt out of the commercial network but remain as TDP
4 providers. In other words, if other commercial
5 networks (inaudible) and how would this impact the size
6 of the networks that you would be able to provide us?
7 This is a question that has come up in the past. So
8 that is something we want to pose to industry to see
9 how we could potentially address this problem, or if
10 it's going to be detrimental to network size.

11 MR. HARBOLD: Tom Harbold with United
12 Concordia. Now providers will not be given the ability
13 to opt out of commercial networks and remain as TDP
14 providers. How would it impact the size of the
15 network. If you gave them that option, I don't think
16 it would have a significant impact. And I do believe
17 in a lot of cases the fact that you tie the two
18 together, to use the phrase, works to the advantage of
19 both.

20 Certainly there are areas that we would not
21 have in network anywhere near the size we do except for
22 the fact that we with have a fair amount of commercial
23 business that we use to build the network in that area,
24 and the TDP program benefits as a result of that. The
25 reverse or the opposite of that is also true. There

1 are certainly areas where major factors in building the
2 network in the TDP program, and it now provides a
3 network for a commercial business.

4 But if you start allowing dentists to start
5 to opt in and opt out of which program they want to
6 participate in and which one they don't, first it will
7 be chaotic, but secondly, I think all programs will
8 lose in one fashion or another from doing that.

9 COL. CONCILIO: Thank you. Any other
10 comments along those lines? So I think overall, if I'm
11 understanding industry correctly, to say keep it as is,
12 it's not a good idea to go to a TDP only network.

13 Next slide please. Here we're finally
14 getting to the subject of potential OCONUS provider
15 networks. As you probably are aware, there is not such
16 a thing in existence now. It is really up to our
17 dental commanders overseas to try to go to local
18 providers in the area that they're located in and
19 develop a list of acceptable practices in that area
20 that they feel meet infection control standards and
21 would be delivering appropriate levels of care to their
22 patients.

23 However, we want to see from industry whether
24 it would be appropriate or even feasible to develop
25 some type of network in OCONUS locations. And we're

1 talking about non-remote areas here, any areas where
2 there's significant populations of our family members
3 to make it worthwhile to even consider developing
4 networks.

5 The question that we have as far as this --
6 when we ask the question, we didn't really get that
7 specific. We want to make sure that we know what
8 industry is saying. We said yes, it is possible to
9 develop some kind of network in those non-remote areas,
10 but we're not sure whether you mean a list of
11 providers, which is essentially what we have now, or a
12 comparable list of what we have CONUS, which I think is
13 slide 17, with certain access standards. Not
14 necessarily same credentialing that we use in CONUS,
15 but appropriate credentialing to the overseas locations
16 in the country where the provider is located in. Or
17 what are your thoughts as far as what your considering
18 an OCONUS network to be, and what it's requirements
19 would include?

20 MR. DAWN: Lowell Dawn. Without a doubt,
21 there's no reason that you should not want a network
22 established in OCONUS regions as long as you to do what
23 you just described in recognizing what the local
24 economy, what the local profession does and doesn't do.
25 The one thing that probably would not work in most

1 locations is the specific mileage and requirements, and
2 we're only guessing. But I certainly would recommend
3 that you do establish a network requirement and that
4 you consider what is available in the local economy and
5 allow your contract to describe the necessary steps to
6 assure that the providers are providing appropriate
7 care as far as health standards, et cetera.

8 COL. CONCILIO: In those OCONUS networks, you
9 obviously have the local providers that aren't really
10 familiar with the concept of insurance necessarily.
11 Your CONUS networks, you have a certain fee schedule
12 your network providers have agreed to accept. How
13 would you approach that realistically in an OCONUS
14 location?

15 MR. DAWN: Well, that's going to vary from
16 country to country. As far as Delta is concerned,
17 we've been paying claims for services provided around
18 the world for decades. It doesn't seem to be a big
19 problem. We don't hear many complaints from our
20 covered individuals as far as them having to pay out of
21 pocket up front, that kind of thing. Most of them
22 expect when they're overseas, they're going to be
23 adhering to whatever the local custom is. So those
24 kinds of things don't seem to be a problem. But it
25 will be different from country to country and location

1 to location.

2 COL. CONCILIO: In your overseas locations,
3 the providers in your network have agreed to accept a
4 certain fee scheduling in the particular area they're
5 in?

6 MR. DAWN: Not necessarily. Some yes, some
7 no.

8 COL. CONCILIO: So are you still paying fees
9 for services essentially? Or how can we incorporate
10 some type of cost control in these areas.

11 MR. DAWN: Well, the cost controls are going
12 to be pretty much patient doctor determination as far
13 as what is reasonable in the location. We can help or
14 anybody representing in this room I think could be over
15 there developing networks, sitting down, talking with
16 dental offices, and encouraging participation with
17 schedules, whatever it might be. There's a lot of
18 options. But to prescribe that across the part as a
19 100 percent requirement would not be a reasonable thing
20 for you to impose on the concept.

21 COL. CONCILIO: And you're also talking in
22 non-remote areas where you have significant population.
23 Would it be good for us to designate which countries or
24 areas that we would want?

25 MR. DAWN: I think the areas -- the

1 non-remote situations may or may not be more difficult
2 or easier. I'm not smart enough to answer that. But
3 any place that you have a significant presence already
4 and the medical community -- the defense medical
5 community is already out there on the economy, any of
6 us can do a much better job for you. There would be a
7 lot more current understanding, and we can do a good
8 job. But the encouragement here is that you recognize
9 that it's going to be different from country to
10 country, from location to location, that you don't
11 prescribe anything across the board that is too
12 onerous.

13 COL. CONCILIO: If you wanted to have
14 (inaudible) beneficiaries CONUS and OCONUS, which is a
15 little bit different from OCONUS. And we wanted to
16 still maintain a constant premium for everyone. How
17 can we develop the network overseas and incorporate
18 those costs in the contract without overly increasing
19 premiums cost for everybody?

20 MR. DAWN: Probably by selecting -- and I
21 think this is being done in other contracts where the
22 national capital area fee basis is used to establish
23 reimbursement for OCONUS reimbursement tied into that.
24 No matter where you are, CONUS, your folks, or covered
25 individuals, make informed decisions every time they

1 select a new dentist. Some elect to find someone with
2 a very low fee. Other pick someone with a very high
3 fee. And that's something that they make decisions on,
4 and stick with it. The copayment is the equalizer in
5 this case, and we'll decide to pay more out of pocket
6 cost or less out of pocket cost on our own volition.

7 COL. CONCILIO: If we decided that we didn't
8 want OCONUS patients to be penalized an extreme amount
9 due to potential cost overseas, is there any way we can
10 do that without affecting the premiums adversely to a
11 significant extent?

12 MR. DAWN: That I'm not smart enough to
13 answer. I think that's something you might want us to
14 get back to our shops and spend some time and get back
15 to you later on.

16 MR. MATZKE: Mark Matzke again. Not to be a
17 wise guy, but gosh, I just really want to, once again,
18 to reiterate -- kind of going back to the last slide.
19 There was questions about double networks even in the
20 continental United States. More often than not, given
21 a reimbursement limitation that's put into the
22 contract, I would argue almost that most folks who
23 have -- well, maybe the incumbent -- I can't imagine
24 that the commercial network would be the same only
25 because it would be at a significant competitive

1 disadvantage with what other carriers are doing and how
2 their doing on the contract, and their ability to
3 contract lower rates. I think there's substantial
4 savings there.

5 COL. CONCILIO: Are you including OCONUS in
6 that?

7 MR. MATZKE: Well, to the extent you don't
8 have a network over there. But you're tossing around
9 some ideas on how to keep level premiums and protect
10 yourself against spending too much money outside the
11 United States, I think there's a huge opportunity here
12 given the current network to take advantage of some
13 deals people have to lower your cost (inaudible).

14 MR. HARBOLD: Tom Harbold, United Concordia.
15 I think there are a couple of other questions you also
16 need to address as it relates to this question of
17 networks in the OCONUS areas. Today, most of the care
18 that family members obtain OCONUS is still obtained
19 through the military treatment facilities. So I think
20 one question you need to address is, are you still
21 going to provide access to your military treatment
22 facilities in the OCONUS areas. Or is the intent to
23 basically eliminate or do it a with access to care
24 through the military treatment facility.

25 I think that's a huge question because today

1 a lot of people first disenroll from military program
2 knowing that they can get care through the military
3 treatment facility. If in the next contract they no
4 longer have that access, that will have impact on the
5 number of enrollees that are in the OCONUS areas. And
6 certainly, if they -- those who are enrolled, whether
7 it's a small number or large number, cannot get care at
8 the local DTF, they have no alternative. They have to
9 go out in the economy, and that will add significantly
10 to the amount of care delivered there, and thus, the
11 cost to the program. So I think that's one thing
12 you're going to need to clarify or address in terms of
13 OCONUS if you're going to put the burden on the carrier
14 to develop a network.

15 And the other thing is, I think -- I don't
16 know much about how the dentist practice within those
17 countries, but my sense is the term network as we use
18 it here and all the baggage so to speak that goes with
19 it from the provider's perspective is not something
20 that dentists in a lot of foreign countries deal with.
21 And I would anticipate that you will have difficulty if
22 you try to use the same type of standards and
23 requirements for a network even if you limit it to the
24 non-remote areas if you try to use the same
25 requirements, same standards there that we tend to

1 associate with a network here in the states. I can
2 appreciate perhaps a desire to have the contractor more
3 involved in making available or having available a list
4 of dentists who can treat people in the OCONUS areas.
5 But I don't think you can expect whatever you end up
6 with in terms of list that's going to adhere to the
7 same standards.

8 COL. CONCILIO: Thank you for your comments.
9 I think you've addressed most of our questions along
10 these lines. And again, I think what Tom brought up is
11 true. We will have to look at access within our own
12 military facilities as well because obviously it will
13 impact.

14 Along those lines, I am going to turn the
15 discussion over to Lieutenant Colonel Edwards. But
16 first, he is going to talk more about quality assurance
17 from performance measures. And I just want to get some
18 feedback from the group about other benefits
19 themselves, procedures codes, or other things you would
20 like us to look at or consider for types of procedures
21 to consider before we move on to the next set of
22 topics. Is there anything else that we didn't
23 specifically address in our concerns that you would
24 like to bring up with us as things that you think from
25 the perspective of our program we should be looking at

1 to?

2 MR. DAWN: Lowell Dawn. I would say you have
3 well covered it already. This -- the benefit design of
4 this contract is as good as anything out there. It's
5 very appropriate for the population you serve. It's a
6 very rich benefit undoubtedly, and it's already very
7 very well designed. We don't have any specific
8 suggestions that you add anything.

9 COL. CONCILIO: Thank you. Anybody else.

10 MR. MATZKE: For what's it's worth -- Mark
11 Matzke. I know that there's two separate plan designs
12 based on, I believe it's grade levels. The (inaudible)
13 service from a function standpoint are really similar
14 with the exception of a couple benefits (inaudible). I
15 think (inaudible) related to benefit making them the
16 same.

17 COL. CONCILIO: You said -- are you talking
18 E-1 to E-4?

19 MR. MATZKE: Yeah.

20 COL. CONCILIO: That one population.

21 MR. MATZKE: Yeah.

22 COL. CONCILIO: Okay. Any other things on
23 benefit itself and procedure codes that we should be
24 looking at? Okay. I'm going to turn this over to
25 Lieutenant Colonel Edwards.

1 LT. COL. EDWARDS: I certainly appreciate the
2 opportunity to be here today. And I've learned a lot
3 already. I appreciate -- I'll try to hold it up and
4 try not to make too much other noise. This has really
5 been helpful to me, and I hope it's been helpful for
6 you -- I'll try to get this done. I only got about
7 three lines.

8 If you guys need to take a break now, we can
9 do that. Or I can go through my slides, and it will
10 probably be an appropriate time to break for a lunch.
11 That's a what I would prefer to do, but I'm -- proceed,
12 okay.

13 I'm really here today to talk about quality
14 assurance, quality improvement plans, outcomes, and
15 performance measures. And a little bit later I'm going
16 to talk about some -- submission of data. We're really
17 interested in quality assurance and trying to
18 understand the benefits to our enrollees that our plan
19 may provide. And what I want to really talk about is
20 understanding how we may be improving the health of our
21 beneficiaries through the benefits that we provide in
22 the plan. So that's sort of the background for a lot
23 of what you saw on our website, and what we've been
24 talking about today.

25 We asked what would be the impact to the

1 industry if we required a submission of a quality
2 improvement plan in your proposals. And the
3 overwhelming response was that there really would be no
4 impact to the industry, but it would positively impact
5 our program. And I was very pleased to see that
6 response.

7 A follow-up question that we might have
8 though is, how much additional administrative cost
9 might this place on the contractor to develop a quality
10 improvement plan? Do we have any responses to that?

11 MR. DAWN: Lowell Dawn. This is just a basic
12 part of the cost for doing business. There certainly
13 is an administrative cost component that would go along
14 with it, but it's something that we all do. And it
15 would be very very appropriate for you to require it as
16 part of the RFP.

17 LT. COL. EDWARDS: Thank you. Any other
18 comments? Thank you. Now, I want to get into an area
19 of -- that we want to address, and that would be how
20 you handle licensure and credentialing and also
21 malpractice coverage by providers. And the next
22 question that we asked was, does the industry require
23 providers to submit evidence of malpractice insurance
24 coverage before you accept them into your network. We
25 really received mixed responses. There was a lot of

1 variability to the answers. And I guess what we would
2 like to do is sort of pin you down, if we could, so we
3 would know the direction that we might want to consider
4 to go in the next contract. How would you recommend
5 that we handle this? Is it something that is
6 beneficial for our program that we would know if our
7 providers in the network had malpractice insurance
8 coverage?

9 MR. DAWN: Lowell Dawn. This certainly is
10 something that is, again, a standard part of our
11 industry. It is something that should be required as
12 part of the RFP. The best way to manage it, because
13 there are differences state to state with state law and
14 difference of that sort, the best way that we would
15 suggest you managed it is that you do require it and
16 ask that it comply with our commercial standards.

17 LT. COL. EDWARDS: The standards of the state
18 in which the practitioner resides or practices?

19 MR. DAWN: You probably have more teeth in it
20 requiring it to our own corporate commercial standards,
21 I believe. There are some states that you would have a
22 hard time finding anything in writing.

23 LT. COL. EDWARDS: Thank you.

24 MR. HARBOLD: Tom Harbold from United
25 Concordia. I wanted him to be the first one so I could

1 disagree with you. I think if you have managed care
2 networks, there's a tendency to require some type of
3 proof of malpractice insurance coverage. The HMO I
4 think is a pretty common requirement. I don't know of
5 any (inaudible). I'm not sure it's quite as common on
6 what I simply refer to as fees for service, and I do
7 see this program at least in its current -- as it
8 currently exist as a fee or service program.

9 The other question is, what do you mean by
10 evidence of malpractice. We have an application form,
11 and I think a lot of contractors and a lot of carriers
12 use application forms. One of the questions on there
13 is, do you have malpractice coverage. If they say yes,
14 maybe that's evidence. Others may require a copy of
15 the face of their malpractice policy, so to speak, to
16 be submitted to the carrier so they have an actual
17 document in their file.

18 My sense is -- certainly United Concordia
19 today, we do not require providers to submit a copy of
20 their face page of their malpractice policy. So we may
21 have to define what you mean by evidence. A simple yes
22 to a question on an application form, is that evidence,
23 or do you require a hard copy document to be submitted
24 by the providers and be placed in the files.

25 LT. COL. EDWARDS: Thank you. Any other

1 comments? The next question that we were interested to
2 have comments on was how you handle queries to the
3 National Practitioner Databank. Is that a standard
4 practice for you included in providing your network?
5 Do you query the databank? We also received mixed
6 responses to this question, and we'd like to hear what
7 you recommend.

8 MR. HARBOLD: Tom Harbold, United Concordia.
9 DHMO I think is pretty much a requirement query, the
10 National Practitioner Databank. Fee for service, I
11 don't think -- I know we don't, and I don't think a lot
12 of carriers strictly do a fee for service type network
13 or necessarily query the National Practitioner
14 Databank.

15 I'm also somewhat of a skeptic as to what
16 value you derive by getting a report back from the
17 National Practitioner Databank since there are a fair
18 number of incidents that have to be reported there that
19 don't necessarily mean that provider has a problem.
20 Insurance companies and malpractice companies settle
21 claims not necessarily because of the merit of the
22 claim, but because of the cost of litigation that would
23 be involved.

24 LT. COL. EDWARDS: Thank you.

25 MR. DAWN: Lowell Dawn. And I agree with

1 Tom. A couple other things for you to consider though,
2 the database is insufficient to be meaningful in many,
3 many, many cases, and then as Tom mentioned there is an
4 awful lot of data in there that has no reflection
5 whatsoever on the quality of care or the ethics of
6 providing care or anything else by the provider. It
7 has to do with the legal side. It's also a fairly
8 expensive involvement, and that cost would be worn by
9 the program because it's just not done otherwise.

10 LT. COL. EDWARDS: I guess, a follow-up
11 question might be, how does the industry identify
12 errant or providers who provide poor quality of care
13 and what do you do about this?

14 MR. DAWN: Lowell Dawn. All of us, I think,
15 are probably doing pretty much the same things in
16 dealing with the data that is available from the
17 licensing agencies, our own office visits, patient
18 communications, et cetera.

19 MR. HARBOLD: Tom Harbold, United Concordia.
20 And I would agree with Lowell's observations. Feedback
21 in terms of specific problems that they have
22 encountered, certainly we investigate each one of
23 those. And I suspect most contractors or carriers do.
24 We have a fairly extensive implementation where we use
25 (inaudible) retrospective process where we look to

1 audits of providers. We do follow actions that are
2 taken by state dental boards. So there are a variety
3 of ways I think you can monitor the quality care of the
4 network. It's not foolproof. I think overall it deals
5 with the problem fairly.

6 LT. COL. EDWARDS: When you identify a
7 provider who may not provide quality care, what's the
8 follow-up process? Does that go back to the state
9 licensing board, or how do you handle that?

10 MR. HARBOLD: Well, very rarely would it go
11 back to the state licensing board. There are occasions
12 where we think the situation -- usually it's not one
13 situation, it's a series of situations, that merit that
14 type of thing. But in a given instance, we usually
15 tried to fix the problem. If we've paid money for the
16 service, and we usually have.

17 We expect (inaudible) only to us, but any
18 cost share that the patient may have paid for the
19 service. If it's an isolated incident, we simply keep
20 a record of that. If we see a series of those
21 involving a provider's office, more than likely it
22 would result with removal from the network. If the
23 offenses are considered to be of such severity in terms
24 of endangering the patient's health, yes, that would be
25 a referral item to the State Dental Board.

1 So it really depends a little bit on the
2 circumstance and the particular situation and whether
3 it's an isolated or appears to be an isolated incident,
4 or whether it appears to be simply a small part of a
5 much larger problem. I would also say that our
6 personal experience is, is that state dental boards
7 tend to be somewhat ineffective in dealing with those
8 situations for the most part.

9 LT. COL. EDWARDS: Thank you. Any other
10 comments. Our next questions is how you monitor -- it
11 deals with how you monitor licensure and credentialing,
12 recredentialing of your network providers, and we
13 wanted to know if you (inaudible) prime resource
14 verification. And the overwhelming majority of you
15 said that you do query the state licensing boards to
16 determine that the dentist is licensed.

17 And the follow-up question to that was, how
18 often do you verify licensure and credentialing. And
19 we got a variable of responses, anywhere from a range
20 from two to four years. Again, I think we'd like to
21 narrow that range somewhat. Follow-up question that we
22 have is, how do you verify credentials? Do you do that
23 in-house, or do you use a credentialing verification
24 organization? It may not be something you want to talk
25 about today. You're welcome to submit your comments to

1 the website.

2 And I'm also wondering if you have considered
3 using the NCQA National Carrier Quality Assurance for
4 every three years for recredentialing. That may be
5 something you want to think about and submit your
6 comments to the website.

7 This slide is nothing but questions. After
8 we receive the feedback from the participants,
9 naturally as we're reading through it, there's a lot
10 more questions. These questions have to do with
11 outcome measures and how we could develop some
12 meaningful outcome measures in our program.

13 I wanted to quote to you from Dr. Ken Kaiser
14 who is the President and CEO of National Quality Forum.
15 And he says that health care performance data should
16 provide meaningful information about whether care is
17 safe, timely, beneficial, patient centered, equitable,
18 and efficient. And I think that's really a very
19 good -- I mean, if I had to define health care
20 performance and the data, I couldn't have done a better
21 job. I think he did a great job. I so I think all of
22 those things included some of the outcomes and measures
23 we might be looking for.

24 How many measures would you include in a
25 dental health plan report card? And if you thought

1 about it -- had much time to think about it, how many
2 measures and what measures would you include? This
3 again may be something you want to think about and
4 submit to the website.

5 You probably remember seeing some sample
6 performance measures on the website that we sent out
7 with the original questions. Certainly those are just
8 some ideas that we're throwing out. So please provide
9 us some feedback on that. We would appreciate it. And
10 I guess the next question, can industry develop outcome
11 measures to show dental health improvement in program
12 beneficiaries?

13 MR. LESLEY: Craig Lesley. The answer is
14 yes.

15 LT. COL. EDWARDS: That's all I'm looking
16 for. That's great it's close to lunch time. Are data
17 currently available to produce performance or outcomes
18 measures? Can you do that with the data you have
19 already? And I'm seeing some head nodding, like that.
20 Did you get that.

21 MR. HARBOLD: Tom Harbold, United Concordia.
22 I think you're getting into a very complex subject. I
23 think it's an area that could be a fascinating area for
24 some type of further exploration or perhaps a joint
25 effort with TMA and the services and the contractor. I

1 think part of question is, what do you want to measure.
2 Things that may fit into making that measurement, we
3 can make some judgements or measure some things based
4 on the services that have been submitted to us. But
5 how do you measure or how do you evaluate those
6 individuals that did not receive treatment?

7 One of the concerns that I have -- we have,
8 is the whole questions of over utilization, providing
9 care that's simply not necessary, which tends to be
10 highly judgmental (inaudible) increases to an
11 individual basis typically (inaudible), and every
12 patients that walks through the door. I think there
13 are a number of areas, but I think they require some
14 pretty in depth look and concerted effort. I'm not
15 sure if that's what you're looking for in terms of a
16 report card.

17 Record cards tend to be how many patients
18 went to the dentist this year, how many of them have a
19 cleaning, how many had x-rays, how many had this, and
20 how many had that. I'm not sure that's necessarily
21 indicative of quality in a lot of cases. Sometimes the
22 best treatment is no treatment. And that's pretty
23 difficult to measure particularly if the claim is there
24 and the treatment is already done.

25 So I think it would be a very interesting

1 area to explain. I'm not sure where you ended up in
2 doing this, and where you thought you might when you
3 started. There's a huge amount of data out there.
4 This program has now something of approaching 16 years
5 of experienced data in terms of patients who have been
6 treated under. Individuals who got sealants didn't
7 really preclude them from requiring restorations at a
8 later date. (Inaudible) higher carries index, higher
9 level of restorative care at a later date.

10 Those individuals who got periodontal
11 treatment five years later, do they still have all of
12 their teeth. Probably the one place that we have not
13 done a good as -- one area we have not explored as
14 fully as I would have liked to are those types of
15 questions. We pay a huge amount of money out under
16 this program for care. I guess the question is, does
17 it really make a difference. I think it does. And I'm
18 sure it does in some instances, but I'm not sure that
19 we always get a dollar value for a dollar payment.

20 I don't think we're going to get there
21 through comments at this particular forum or even over
22 the internet, but I think it would be a very
23 interesting area to sit down and explore it in some
24 department. And I think you want to get input from a
25 variety of parties to what do you really want to try

1 and measure, what are you looking for, and where do you
2 want to end up.

3 LT. COL. EDWARDS: Thank you for your
4 comments.

5 COL. CONCILIO: Along those same lines, I
6 think you were getting at some of the things we were
7 looking for as far as outcomes down the road, not
8 necessarily just utilization patterns, but also
9 reaching an area of good dental health. And some of
10 the things you mentioned I think are outcomes along
11 those same lines. Another thing you could be looking
12 at are people that finally reach a point where all they
13 need when they go to their dental office is just an
14 exam, a cleaning, and no further restorative treatment
15 because they have reached a certain level of dental
16 health. And I think from our perspective, we are
17 reaching that point in some cases and not in others.
18 And those are the things I think you want to start
19 looking at as far as outcomes.

20 LT. COL. EDWARDS: Thank you. This next
21 question was prompted by some feedback that we received
22 over the website. Does the industry capture data by
23 dental record abstraction? This may be something you
24 want to talk about and get back to us.

25 MR. DAWN: Lowell Dawn. Could you define

1 what you mean by dental record abstractions?

2 LT. COL. EDWARDS: Dental record abstractions
3 is a very common concept of managed care support
4 contracts, whereby we actually have a contractor,
5 Mr. Rubin, talked about that contract this morning. I
6 believe it was Maximus. They actually go in and pull
7 records and abstract data from the records quality
8 data, and then make determination on whether quality of
9 care was provided or not.

10 MR. DAWN: Then the answer is yes, the
11 industry does do that.

12 LT. COL. EDWARDS: Thank you. Again, this
13 may be something you want to get back to us with more
14 comments on the website. Are data independently
15 audited? Again, this question was prompted by feedback
16 we received on the website. Okay.

17 What will be the impact on our program costs
18 if we require that you develop a quality improvement
19 plan with specific outcome measures? Just more time
20 for homework, I guess.

21 Let's talk a little bit about claims data
22 submission. We asked the question if the industry had
23 the technical capability to transmit to a central
24 repository, and the overwhelming response was yes. We
25 also asked the preferred method of data transmission.

1 We received a couple of answers encrypted FTP, which
2 I'm not a techie at all, so I think that means file
3 transfer protocol. And then another response we got
4 was EMC, and we have no clue what that is. But what we
5 would like to ask you is, what would be the preferred
6 method to ask for that data? If you had to transmit
7 the data to TMA for us to place in a central
8 repository, what's the easiest way for you to get the
9 data and make the least impact on the contractor? You
10 may want to think about it and get back to us on that.

11 I'm asking some tough questions. I'm sorry.
12 What impact will this requirement have on the cost of
13 the contract, and the overwhelming response was
14 typically minimal costs. But it also depended on the
15 amount of data that we required and frequency of data
16 transmissions, which I think we all understand that.

17 Any further comments about data transmission?
18 Okay. I am done unless you got further questions of
19 me. My arm is about giving out here. Thank you for
20 your time.

21 MS. HEAD: I'll just address the last slide
22 from here if you don't mind. Even if you do, I'm doing
23 it from here. The next two questions on this slide
24 come from just claims processing dealing with other
25 health insurance, and during the processing of a claim

1 when the benefit has been exhausted. These are just
2 some extra questions that actually did go out on the
3 web. I'm not sure anybody realized they were put out
4 there. But in the meantime, just looking for basic
5 claims processing information on dealing with other
6 health insurance. First one is, how does -- if you are
7 the second payor, how do you calculate your financial
8 responsibility on the claim?

9 MR. LESLEY: Craig Lesley, Delta Dental Plan.
10 Coordination of benefits is probably one of the most
11 complicated areas of claims administration, whether
12 it's hospital, surgical, medical, or dental. And I
13 would say that our organization, and I assume others,
14 have two or three or four different ways to administer
15 it. And we've had to develop those different options
16 because there have been different requirements put upon
17 us by different customs.

18 So one method would be that the secondary
19 payor would calculate their responsibility to be no
20 greater than the bill charges of the dentist. Another
21 would be that the second payor would pay no more than
22 what they would have been responsible to pay if they
23 were primary. Two entirely different methods of
24 calculation. And then the maximum payments to the
25 dentist would be determined by the presence of the --

1 A, whatever the policy was on the first part, and then
2 B, the maximum allowable charge that the plan allows
3 for that dentist for that procedure of whatever contact
4 may be in place.

5 So you have to be very careful in prescribing
6 the method in which you want that calculation to be
7 done. And there are two or three or four different
8 ways to do it, all of which come up with a different
9 result of out of pocket cost or lack thereof for the
10 family and cost of the plan.

11 MS. HEAD: Thank you.

12 MR. HARBOLD: Tom Harbold, United Concordia.
13 There are various ways, and at times it does depend on
14 the specifications of the contract. At United
15 Concordia, we differentiate (inaudible) coordination of
16 benefit situations versus non-duplication situations as
17 we refer to them sometimes. And there are different
18 things or different approaches there are different
19 things (inaudible).

20 In general, what we tend to look at in terms
21 of coordination of benefits, at one time when we were
22 the secondary payor, we would coordinate to the
23 dentist's charge. That was some time ago. We've
24 gotten away from that. Now, if we can determine that
25 the treating dentist is a participating provider with

1 the primary carrier, we tend to coordinate up to that
2 carrier's allowance with the understanding that the
3 dentist has agreed to accept that allowance for payment
4 in full. So we conclude that there should be no added
5 out of pocket expense for the patient.

6 And our payment many times will take care of
7 paying the cost share that they would have been
8 responsible for under the primary carrier's policy. If
9 we cannot determine that they are a participating
10 provider with the primary insurer, then today we still
11 coordinate the charge. That's our most common approach
12 on our fee for service programs.

13 MS. HEAD: Thank you. And then the second
14 topic was if during the processing of the claim, the
15 beneficiary has already exhausted his benefits, yet he
16 went back for additional treatment. Do you hold -- are
17 network dentists required to honor the negotiated
18 discount that you have with them even though the
19 beneficiary succeeded their \$1,200 maximum? I'm
20 getting a yes. There's Tom Harbold nodding negative.
21 I didn't hear that back there.

22 MR. HARBOLD: We do not currently. Once they
23 have exhausted their benefits, we tend to view the
24 service at that point as a non-covered service. And
25 most of our provider contracts permit the network

1 dentist to bill their normal charge for covered
2 services. We probably are a little different than at
3 least a number of carriers in that respect.

4 MR. GANUNI: Jerry Ganuni. On the commercial
5 side, we're building the network. The dentist
6 generally does not know what the benefit programs are.
7 So as a result, the contract fees or anytime a
8 participant in any of our programs visits one of our
9 network dentists, the negotiated fee does always apply.

10 MS. HEAD: And then the second part, are they
11 allowed to bill an enrollee up to bill charges? And I
12 think we had mixed response on that already received.
13 It's probably a segue to.

14 Does anyone have any questions before we
15 break? If not we've allotted an hour time frame for
16 lunch. We'll meet back at -- or I've been told you
17 have another option. If we continue on through the
18 rest of the slides and just finish, and you have a
19 later lunch today, it's your decision. Keep going.
20 We'll have a short break, and then we'll come back.

21 (Recess from 11:33 a.m. to 11:50 a.m.)

22 LT. COL. EDWARDS: Before I get started on
23 this next section, I'm going to ask Lieutenant Blighton
24 to come up. He is with TMA resource management. He
25 just wants to give you some clarifying comments on the

1 data (inaudible).

2 LT. BLIGHTON: I'm from TMA. We're just now
3 beginning the development of the data warehousing for
4 dental data. (Inaudible) so when you go back to your
5 facilities and you are thinking about maybe any
6 responses that you want to submit to us, anything that
7 you currently do, ideas on how you would format it,
8 ideas on how you would submit it, types of data that
9 you submit to folks who warehouse or do analysis on, to
10 kind of look at their (inaudible). So that's the kind
11 of (inaudible) we're looking for. Anything you would
12 like to give us from industry to say this is how you
13 currently do that practice, would be a great help to
14 us, and we would appreciate it. So I just wanted to
15 pass that on before we got well beyond that and not
16 thinking about it anymore. Thanks.

17 LT. COL. EDWARDS: The next series of slides
18 I wanted to walk you through is a process that we use
19 to reimburse active duty service member care that is
20 provided in the civilian sector. You saw reference to
21 this on the website and some of the questions that were
22 on the website. And I think a lot of you already
23 replied to those questions. But I really want to kind
24 of walk you through the process of MMSO to give you a
25 better understanding of what we do there.

1 The Military Medical Support Office is
2 located in Illinois, and they manage the
3 pre-determinations, adjudicate claims, and authorize
4 claim reimbursement for private sector dental care that
5 is provided for active duty service members. They
6 evaluate treatment plans and also evaluate dental
7 conditions and dental fitness for duty as well as
8 appropriateness and necessity of care.

9 We really have two populations that are
10 served in this program. The first population served is
11 the remote service members, those service members
12 living and working more than 50 miles from active duty
13 dental treatment facilities. Those service members are
14 designated as TRICARE service remote eligible --
15 TRICARE prime remote eligible.

16 The second population serviced are service
17 members who are actually referred from military
18 treatment facilities out to the civilian sector for
19 care that we cannot provide in our own facilities. A
20 lot of that care is primarily major restorative care,
21 oral surgery type care. It's usually third molar
22 removal. Those kind of things, although some routine
23 care is referred also. The treatment may be obtained
24 from any licensed dentist in the 50 states and the
25 district of Columbia.

1 Now, in this program, emergency care does not
2 require any pre-authorization. Routine treatment can
3 be completed without obtaining pre-authorization if the
4 treatment meets some requirements. The routine care
5 includes diagnostic services, preventative services,
6 routine restorations, and single tooth extractions.
7 The total cost of procedures at the treatment
8 appointment must be less than \$500 to be considered
9 routine care. And the treatment plans that exceed a
10 total of \$1,500 must be pre-authorized if they occur
11 within a calendar year. And all procedures must be
12 covered benefits.

13 So you're probably sitting out there
14 thinking, this kind of looks like -- this is a similar
15 program to what we might even do in an insurance
16 program. We are really working hard to seek
17 alternatives to control the costs of this program. And
18 we have developed some potential options, but we are
19 certainly open for other options. So we're asking for
20 your help and your input on this.

21 One potential option may be to have a
22 separate contract with a discounted fee for service
23 network and administrative services performed by a
24 contractor. And this type of arrangement we would
25 definitely want to continue to have military oversight.

1 Another option might be to make a program like this a
2 component the TDP contract. Again, we'd want a
3 discounted fee for service network and administrative
4 service performed by the contractor, but we would need
5 to have military oversight. Another option might be
6 just to contract out the use of a discounted fee for
7 network and to continue all those functions that we
8 mother format MMSO.

9 Now, you guys are a lot smarter than I am,
10 and you probably can think of some other options. So
11 here's where we really need some feedback from you.
12 Let us know if you think one of our options may be the
13 best way to go, or if you can come up with some other
14 ideas or concepts or options that may even work better.
15 How should we restructure this program to achieve our
16 overall goal of controlling the cost that we're
17 expending for active duty dental care in the private
18 sector? Any comments.

19 MR. DAWN: Lowell Dawn. There are two of us
20 that aren't smart enough to answer the questions, at
21 least as it stands right now. It would be very
22 helpful, I assume to all of us in the room, if you
23 could provide us more information on what the cost
24 issues are, quantify that, give us some indication of
25 geographic location volume, et cetera, and we can put

1 our heads together and do a much better job for you.

2 LT. COL. EDWARDS: Is this something that
3 would be better to offer this as a separate contract,
4 or would this be something this could be a part of the
5 new or next TDP contract?

6 MR. DAWN: Lowell Dawn again. I think it
7 would be much easier for everyone and cheaper for the
8 Government if you just fold it in. It would make an
9 awful lot more sense.

10 LT. COL. EDWARDS: Thank you.

11 MR. HARBOLD: Tom Harbold, United Concordia.
12 It would be helpful to have more detail concerning the
13 existing program. But my sense is that, by putting it
14 on in the commercial environment (inaudible), you can
15 achieve significant discounts that I don't think exist
16 today. And I think that would have a very great impact
17 on the overall cost that you're incurring with
18 (inaudible) today, which I think have gone up somewhat
19 approaching astronomical levels over the last couple
20 years.

21 LT. COL. EDWARDS: It depends on how you
22 define astronomical.

23 MR. HARBOLD: In terms of whether you make it
24 part of the TDP next generation or whether you do it as
25 a separate contract, I don't think it makes a lot of

1 difference frankly. I'm not sure it's going to affect
2 the cost significantly doing it one way or the other.
3 If you make it part of TDP contract, somehow I think
4 you're going to have to finance it in some separate
5 fashion or keep track of the cost. And obviously
6 reimbursing the contractor will have to be
7 differentiated for how they are reimbursed for handling
8 what is now the TDP program, which means it will
9 probably end up being a separate program within the
10 larger program. You have (inaudible) possibly some
11 procurement costs by simply rolling it in. But I'm not
12 sure there are significantly other (inaudible).

13 LT. COL. EDWARDS: I guess I should clarify.
14 In this program, it would be absolutely no cost to the
15 service member and the Government would be 100 percent
16 at risk. I probably didn't make that clear in my
17 earlier comments. Does the industry have any problem
18 with us maintaining military oversight? And what I
19 mean by that, I guess I should explain. We would like
20 to have oversight over treatment plans that come in,
21 reviewing treatment plans, utilization, those kinds of
22 things. Would that pose a problem?

23 MR. GANUNI: Jerry Ganuni. This reminds me
24 of (inaudible) almost much bigger employer not knowing
25 the size of the operation that you have here. But as a

1 ASO and the individual who's taking the full risk on
2 this, you can determine any type of oversight you want
3 us to have. You can process the claims. We can do the
4 act management. We can do just about anything or let
5 you do different components. This doesn't remind you
6 of anything (inaudible) if you set it up as an ASO.

7 MR. PRYOR: Ray Pryor. This is very similar
8 to what's currently happening in the TRICARE contracts,
9 and it's working quite well. It's a change order
10 approximately 18 months ago from a med surg standpoint.
11 This very thing is occurring. The difficulty we had
12 there was determining where all these people were.

13 LT. COL. EDWARDS: I think we certainly have
14 data that we could provide to show you where the
15 eligible population, where the members are located, and
16 also we do have claims data experience. Any other
17 comments on this particular issue? I don't have any
18 other slides to project. If you have follow-up
19 questions or comments, please submit them to us, and we
20 will get back to you very shortly. Thank you.

21 MS. HEAD: This brings us to our last two
22 slides in our briefing today. These have to do with
23 the TDP data requirements. The slides indicate what we
24 currently have available and can provide. It is pretty
25 much standard what we provided in the past. We do have

1 eligible sponsors and children by three digit zip
2 codes, and we can provide by state, territory, country,
3 gender, and age categories. We do have worldwide
4 utilization. And our reports break out those following
5 data elements, the benefit payments by branch of
6 service, enrollment type, age, gender, and CDT code,
7 locality, and claims by dollar range. It's actually
8 four subsets of one overall report that we derive all
9 that from.

10 Enrollment data. We will be using the
11 enrollment as shown in the DEERS database. (Inaudible)
12 given you the complete option period 2 and 3 that we
13 have at this point would be sufficient. And it will be
14 by single and family enrollment types. Workload for
15 claims inquires and appeals, we would also provide that
16 for the most recent two option periods. This is what
17 we currently have.

18 What, in addition to these items, would you
19 be looking for from Government? And I'm just strictly
20 speaking on the TDP next generation, not the MMSO part
21 of this.

22 MR. DAWN: Lowell Dawn. On some of the
23 categories do you intend to break out by active duty
24 versus guard reserve.

25 MS. HEAD: Yes. We do have it by category.

1 MR. GANUNI: Jerry Ganuni. Is there a
2 potential claims payment by dentists so that a network
3 comparison could be made?

4 MS. HEAD: I'm thinking no, that's not an
5 element that we collected or is required to be
6 provided.

7 LT. COL. EDWARDS: If I could follow up just
8 briefly to talk about the MMSO data again, if you will
9 give us an idea of what type data you would need from
10 that program, we'll see what we can do to get it to
11 you.

12 MR. MAYS: Any other questions? Again, I
13 want to thank you all. I think that pretty much wraps
14 up our presentation and questions. I want to thank you
15 all very much for coming here and participating. It's
16 been very helpful. I know we've all gotten a great
17 deal of information that we'll take back and digest.
18 Our plan, for your information -- what we would like to
19 do now is -- over the next month and take this and
20 digest it. We'll probably revise the draft statement
21 of work that you've seen, work on the benefit design
22 some more, and hopefully put out a draft on or around
23 the end of April and invite more comments from you on
24 that.

25 We encourage you, in between that, over the

1 next couple of weeks, if you would, if there's anything
2 that you think of after you leave here, if there's
3 anything that you left open today, if you want to give
4 comments on that, we'd be very grateful to receive
5 those. We're looking for all the assistance we can get
6 here. So please don't hold back on us.

7 Again, this transcript will be available in a
8 week to ten days, and it will be on the website. Any
9 further comments or questions you may have, please send
10 those to the TDP solicitation e-mail address that was
11 on one of the slides in your package. And if there are
12 no further questions or comments, thank you very much
13 for attending. We appreciate it very much.

14 WHEREUPON, the following proceedings
15 concluded at 12:07 p.m. on the 30th day of March, 2004.

16 * * * * *

REPORTER'S CERTIFICATE

STATE OF COLORADO)
) ss.

CITY AND COUNTY OF DENVER)

I, BRANDI L. BURNETT, Certified Shorthand Reporter
and Notary Public, State of Colorado, do hereby certify
that the said proceeding was taken in machine shorthand
by me and was thereafter reduced to typewritten form;
that the foregoing is a true transcript of the
proceedings had. I further certify that I am not
employed by, related to, nor of counsel for any of the
parties herein, nor otherwise interested in the outcome
of these proceedings.

IN WITNESS WHEREOF, I have affixed my signature
and seal this 12th day of April, 2004.

My commission expires October 20, 2006.

Brandi L. Burnett
Certified Shorthand Reporter
Notary Public, State of Colorado